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ABSTRACT

This journal volume focuses on three areas: technology and the appropriate use of the internet for support groups; diversity issues that affect clients and counselors-in-training; and the clinical issues section that provides an integrated view of Attention Deficit/Hyperactivity Disorder and an overview of Dissociative Identity Disorder. It contains the following articles: (1) "Self-Help + Computer = Online Emotional Support" (Juneau Mahan Gary and Linda Remolino); (2) "Thought-Listing: A Research Tool for Examining Attitudes toward Homosexuality" (Lorraine J. Guth, Kimberly D. Clements, Julio Rojas, and David F. Lopez); (3) "Gender and Ethnicity in Identity Formation" (Mark H. Chae); (4) "Acculturation Conflicts among Asian Americans: Implications for Practice" (Mark H. Chae); (5) "Counselor Response Choices to Prejudicial Client Statements" (Eugene Goldin, Melvin Heck, and Eugenia M.K. Morgan); (6) "Biopsychosocial Aspects of Attention-Deficit/Hyperactivity Disorder: Toward a Self-Regulated Behavior Paradigm" (Dale Starcher); and (7) "Literature Review of Effective Treatment for Dissociative Identity Disorder" (Matt Lucariello). (Contains 2 tables, 1 figure, 1 appendix, and 271 references.) (ADT)

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The New Jersey JOURNAL OF PROFESSIONAL COUNSELING

Self-Help + Computer = Online Emotional Support

Thought-Listing: A Research Tool for Examining Attitudes Toward Homosexuality

Gender and Ethnicity in Identity Formation

Acculturation Conflicts among Asian Americans: Implications for Practice

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Literature Review of Effective Treatment for Dissociative Identity Disorder

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Nancy G. Westburg, Ph.D., Editor

Volume 56, Winter 2001/2002

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The New Jersey Journal of Professional Counseling

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The New Jersey Journal of Professional Counseling is published by the New Jersey Counseling Association (NJCA), a state branch of the American Counseling Association. A primary purpose is to communicate ideas and information that can help counselors in a variety of work settings implement their counseling roles and develop the professional of counseling.

Manuscripts: Manuscripts are welcome from all professionals interested in the field of counseling. Guidelines for authors appear in each journal.

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Editorial

The New Jersey Journal of Professional Counseling has a history of publishing high quality manuscripts that are relevant to counselors and other mental health professionals. The American Counseling Association presented a national award to New Jersey Counseling Association (NJCA) in recognition of the caliber of the journal. Manuscripts for this volume of the journal have been submitted by authors from the local area as well as from other states. Continuing the commitment of publishing articles that reflect some trends in the counseling profession and the expanding counseling knowledge base, this volume of the journal focuses on the following three areas: technology and the appropriate use of the internet for support groups; diversity issues that affect clients and counselors-in-training; and the clinical issues section that provides an integrated view of Attention-Deficit/Hyperactivity Disorder and an overview of Dissociative Identity Disorder, an often misunderstood diagnosis.

In order to maintain quality, manuscripts that are accepted for publication in this journal must go through a rigorous process. First, the manuscripts must be relevant to counselors, add to the counseling knowledge base, and adhere to the standards and format of the *Publication Manual of the American Psychological Association*. If the manuscript meets these criteria, it is sent for a blind review to two peer reviewers, who will recommend to accept, accept with revisions, or reject the manuscript. The current acceptance rate for the journal is 60%.

This volume of the journal includes four innovations. First, the journal will be available through Resources in Education database by ERIC, which allows researchers and practitioners throughout the country and world to access the journal. Second, a special student article is featured. This is a way to give promising scholars and practitioners the opportunity to be recognized. The same standards are held for students' manuscripts; however, their manuscripts are reviewed by only one peer reviewer. Third, the journal will be available on the NJCA's web page. This will allow much greater access to the journal. Last, in addition to being sent to members of NJCA, the journal will be sent to selected colleges and universities in New Jersey and Pennsylvania. This is another way to attract counselors and counselors-in-training to join NJCA if they are not members.

I extend many thanks to Dr. Paula Danzinger for her contributions as interim editor of the journal. I also want to acknowledge the time, effort, and expertise that the Editorial Board contributed to ensure the quality of the articles that are published. Their feedback to the authors was invaluable. I also invite your comments about the journal. I encourage you—whether researcher, practitioner, or student—to contribute to the counseling knowledge base by submitting a manuscript to ***The New Jersey Journal of Professional Counseling***. It is only through your contributions that we can continue to provide current and relevant information to counselors and other mental health professionals.

Nancy G. Westburg, Ph.D., Editor

TECHNOLOGY

Self-Help + Computer = Online Emotional Support

Juneau Mahan Gary, Psy.D., Kean University and Linda Remolino, M.A., West Orange Board of Education

Online support groups are a relatively new and growing cyber service. They attract a broad variety of people and provide an alternative vehicle of support through computers by linking people with similar issues such as coping with alcoholism, grief, eating disorders, or depression. We describe the nuts and bolts of online support groups, address their role as an adjunct to counseling, describe their membership, explain their therapeutic effects, and discuss their benefits, limitations, and future direction.

Traditionally, people discuss emotionally distressing issues with someone they know, with someone in a similar situation, with a mental health professional, or they do not discuss the issue at all. Computer technology is now altering the traditional ways some people handle distress and is also changing their standard patterns of communication (Grohol, 2000). Computers and the Internet are now accessible to 50% of Americans through a combination of private ownership, office computers, and computers at libraries, after-school programs, computer centers, and community centers (Harris-Bowlsbey, 2000).

Since the 1980s, people have been discussing their predicaments, distress, and coping skills with others in anonymous cyberspace groups through online support groups and online self-help groups. The terms *support* and *self-help* tend to be used interchangeably, but minor differences exist between these two types of groups (Corey, 2000). Both groups: (a) share emotions; (b) encourage support and the creation of a support system; (c) emphasize the value of affiliation around a common topic, issue, or life predicament; (d) strive for behavioral change, healthy coping skills, or both; and (e) have group leaders who are typically struggling with the same predicament as the membership. Neither type of group promotes the placing of blame for the predicament or the responsibility for solving the situation on someone else (Corey; Meissen, Mason, & Gleason, 1991). Support groups tend to be started by a professional helping organization or individual whereas self-help groups tend to start without a designated leader and emphasize autonomy, helping oneself, assuming personal responsibility, and taking action to resolve the issue (Corey).

The popularity of these online groups, henceforth called online support groups, has soared because of increased access to reasonably priced computers and advances in technology. The online support group is a relatively new and growing cyber service that uses a computer and a connection to the Internet. People communicate with others who are experiencing common issues such as coping with alcoholism, eating disorders, and depression, among other issues. They par-

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ticipate with a level of safety, privacy, and control from the comfort of their home, library, computer center, or community center.

In this article, we have described the nuts and bolts of online support groups, their role as an adjunct to counseling, their membership, their therapeutic effects, and their benefits, limitations, and future direction. We have assumed that the reader possesses basic computer knowledge but may be unfamiliar with online support groups and their therapeutic effects.

MEMBERSHIP IN ONLINE SUPPORT GROUPS

Online support groups attract a wide variety of members. Davison, Pennebaker, and Dickerson (2000) described membership in the typical face-to-face support group. For instance, approximately 3% to 4% of Americans seek self-help or support services during any one calendar year, and an estimated 25 million people seek support during the course of their lifetime. The mean age of members is 43 years and the mean educational level is 12 years. Caucasians participate most actively, followed by Latinos, and then followed by African Americans. Health concerns and the challenges of coping and adjusting to life predicaments are the most frequently stated reasons for joining a support group or self-help group.

Although Davison et al. (2000) described the average member, in actuality, online members vary greatly in age, educational level, occupation, race or ethnic identity, gender, and marital status. Online membership represents a cross-section of society and is broader than the YAVIS-type client (young, attractive, verbal, intelligent, successful) (Schoefield, 1964). The YAVIS-type client has the financial resources and time to benefit from traditional counseling (Hughes, 2000).

Researchers who have studied online support groups have included YAVIS-type and non-YAVIS-type participants and analyzed their use of online support groups. Research on non-YAVIS-type participants has included (a) teenaged mothers (Dunham et al., 1998), (b) people with eating disorders (Winzelberg, 1997), and (c) survivors of breast cancer (Weinberg, Schmale, Uken, & Wessel, 1996). Research on YAVIS-type participants has included social workers with occupational stress (Meier, 1997). The non-YAVIS-type participants may not have perceived themselves as having sufficient time to attend traditional face-to-face support groups (e.g., teen mothers) or may have resisted traditional support groups to avoid family shame or isolation (e.g., people with eating disorders) (Wu, 1999). Thus, online support groups can be attractive to a group of new users who may have previously resisted peer support because of medical, financial, cultural, or transportation constraints that thwarted convening face-to-face or because of feeling too overwhelmed to join a face-to-face support group (Grohol, 2000).

In addition to the demographic diversity of online support groups, the free service attracts members. The combination of a lack of a financial commitment, the freedom and privacy to participate outside of one's medical insurance provider, and the absence of family involvement in financial or insurance business (i.e., parental or spousal insurer signing insurance forms and agreeing to make copayments) promotes privacy and independence. These financial incentives, plus diverse demographics among the members, appear to broaden the base of non-YAVIS-type users in online support groups.

SUPPORT GROUPS AND THERAPEUTIC FACTORS

Research on the efficacy of face-to-face support groups has indicated that members benefit from group participation and a combination of therapeutic factors (Corey, 2000; Schwartz & Waldo, 1999; Yalom, 1995). Mutual support is offered and received, aiding members in adjusting to significant changes and major stressors in their lives by learning from the experiences of others. Members develop a sense of normalization as others disclose similar reactions and members feel empowered about decision-making abilities and personal control (Gore-Felton & Spiegel, 1999; Hurley, 1988; Mehr, 1998).

Yalom (1995) has asserted that self-help groups offer the opportunity for personal growth, social experimentation, and behavioral change through seven therapeutic factors:

1. *Universality.* Group members realize they are not alone and that others experience similar issues and reactions.
2. *Imitative behavior.* Members model different coping skills used by peers.
3. *Altruism.* Participants recognize an ability to help others and this may increase their self-esteem, stimulate a desire to take risks and reduce their dependency.
4. *Instillation of hope.* Positive experiences of peers can motivate others to seek solutions.
5. *Imparting of information.* Peers can evaluate options not previously considered.

6. *Development of socialization techniques.* Members can practice new behaviors.
7. *Corrective recapitulation of the primary family group.* Participants may gain insight into recurring family dynamics and patterns that may affect current relationships.

The therapeutic factors are interdependent and the differential importance of each factor varies depending upon the type of group, group composition, therapeutic goals, and each member's degree of emotional distress and specific needs. Specific to online support groups, Weinberg, Uken, Schmale, and Adamek (1995) concluded that several therapeutic factors had significant therapeutic effects in one online support group for cancer survivors. In particular, the three therapeutic factors of instillation of hope, group cohesion, and universality were deemed the most active of all therapeutic factors and were particularly beneficial for the cancer support group members. These therapeutic factors contributed to the online support group's bonding and perceived helpfulness.

Although current research on the efficacy and perceived usefulness of online support groups is limited, ongoing research is critical to determine if these groups offer therapeutic features similar to the therapeutic features of face-to-face support groups. Preliminary research has suggested positive comparisons and comparable effects (Davison et al., 2000; Harris-Bowlsbey, 2000). In four studies, online support group participants reported feeling supported and connected to others who shared similar issues (Dunham et al., 1998; Meier, 1997; Weinberg, Schmale, Uken, & Wessel, 1995; Winzelberg, 1997). For instance, in one online support group for people with eating disorders, Winzelberg reported that 31% of members disclosed personal distress, 23% gave information (but 12% of the information was inaccurate), 16% gave emotional support, and 15% sought help unrelated to eating disorders.

In addition to positive research results, most member self-reports have been positive. Members perceived online support groups as being helpful, validating, and supportive, and most would not continue to participate without some perceived benefit (Callahan, Hilty, & Nesbitt, 1998; Meier, 1997). However, dissatisfied members cited three issues that created a barrier to their participation: (a) an absence of visual, auditory, and interpersonal cues, (b) a sense of isolation for those who prefer face-to-face interaction, and (c) technology problems such as being disconnected (Galinsky, Schopler, & Abell, 1996).

Although face-to-face support groups are effective in assisting many people in coping with feelings and with improving coping strategies, they also have obstacles that limit their efficacy. Face-to-face support groups require that: (a) services be available in the member's geographic area, (b) everyone convene at the same time, (c) issues of cultural stigmatization and social status about seeking support external to the family be resolved, (d) membership fees be paid, (e) obstacles that are caused by being housebound be overcome, or (f) transportation arrangements be made (Weinberg, Schmale, et al., 1995). Although face-to-face support groups help many people, they are not a panacea. For those unwilling to use face-to-face support groups or for those unable to benefit from face-to-face support groups, online support may be an appropriate and effective alternative support network (Grohol, 2000).

NUTS AND BOLTS OF ONLINE SUPPORT

Online support groups offer many features of face-to-face support groups but do so using cyber groups. Similar to face-to-face support groups, online support groups can range from serving as one therapeutic component of an intervention plan or comprehensive mental health treatment plan to serving as the sole support system.

Access

Online support groups can be accessed through use of a computer and a modem in conjunction with a major Internet Service Provider (ISP) such as America Online (AOL) or in conjunction with a local ISP. Once connected to the Internet, online support groups may also be reached through Internet portals (e.g., Yahoo) or through commercial Web sites (e.g., www.psychcentral.com). Major ISPs, large commercial Web sites, and portals set individual standards and procedures regarding regulations, quality control, crisis management, disclaimers, and training of group leaders.

Format

Online support groups can function in real time (i.e., synchronous groups); through E-mail discussion groups, also called listservs, bulletin boards, or newsgroups (i.e., asynchronous groups); or through a combination of these formats. The synchronous format is similar to participating in a telephone conference call

TABLE 1

Sampling of Support Groups, Self-Help Groups, and Web Sites

Addiction
www.addictions.com
www.addictions.net
www.aa-intergroup.org
www.na.org
www.recovery-man.com

Internet Addiction
www.netaddiction.com

Anxiety
www.anxietydisorders.com
www.social-anxiety.com
www.stresscenter.com

Culture-based
www.nativeweb.com

Depression
www.psycom.net

Eating Disorders
www.eating-disorder.org

Gambling
www.800gambler.org

General Mental Health
www.mhsource.com
www.apa.org
www.psychcentral.com
www.mentalhelp.net
www.soulselfhelp.on.ca
www.psychwww.com
www.counseling.org/consumers_media
www.mentalhelp.net/selfhelp

Grief/Loss
www.death-dying.com
www.shiningsouls.com
www.survivingsorrow.org

Hospice
www.hospicenwo.org
www.evergreenhealthnet.org

Suicide
www.suicidology.org
www.suicidepreventtriangle.org

Other Sites

Portals and Web Sites
www.yahoo.com (multilingual Yahoo! sites worldwide)
www.webmd.com
www.ivillage.com
www.aol.com (multilingual world service sites)
www.msn.com (multilingual world service sites)

Mental Health Resources for Clinicians
cybercounsel.uncg.edu
www.behavior.net
www.behavior.net/JOB (Journal of Online Behavior)
www.apa.org
www.griefsupport.org
www.mhsource.com
www.counseling.org

that is text-based, whereas the newsgroup format is similar to sending E-mail and awaiting responses. Both formats are described.

Synchronous groups. Real-time online support groups are interactive and simulate discussions with others using text-based communication. They meet at a scheduled time to encourage consistent participation and convene for, on average, one hour. These groups are sometimes called chat rooms, but not all chat rooms (e.g., open chats) are online support groups. In synchronous groups, members receive immediate support, feedback, advice, and information. They correspond anonymously and use contrived screen names (i.e., pseudonyms). They take turns communicating and can communicate with the whole room or converse with an individual as others follow the dialogue on their personal computer screen.

Typically, group sessions are not printed and the leader does not maintain session notes. The quality of each session differs and is based on the composition of the group, the cohesiveness of the group, the relevance of the topic, the group facilitation skills of the leader, and the members' pressing issues. An excerpt from a typical online support session for loss and grief issues can be found in Gary and Remolino (2000). Examples of online support groups and Web sites are included in Table 1 and demonstrate the range of topics that can be discussed.

In spite of the lack of physical interaction and absence of nonverbal communication, limited expressions of emotions are conveyed symbolically, visually, and in shorthand by *emoticons* as illustrated in Table 2. Emoticons are strung-together keystrokes that resemble facial expressions when turned 90 degrees clock-

wise. Emoticons can facilitate the transmission of humor, levity, or disappointment, which may be difficult to communicate in text-only communication (Collie, Mitchell, & Murphy, 2000).

TABLE 2

Cyber Shorthand and Symbolic Expression of Emotions

Emotions	***Symbols***
Hug to others:	{{{{{0}}}}}
Hug to the entire room:	{{{{{room}}}}}
Hug and kiss:	{}&**
Smile:	:) and :)
Frown:	:(
Shorthand	***Symbols***
Long time, no see:	LTNS
Laughing out loud:	LOL
Cursing:	&!$#*&
Yelling:	Capitalize word (e.g., he HATES that)

Asynchronous groups. Members post messages and questions 24 hours a day, 7 days a week in more than 40,000 online listservs, bulletin boards, newsgroups, or E-mail discussion groups (Davison et al., 2000). Messages are posted to a specific person or to the general membership. This format allows members to send and retrieve messages at their convenience and regardless of their time zone. However, responses are delayed while the sender awaits replies; support is not immediate.

Group Leader

Leaders facilitate synchronous online support groups and may be called hosts or moderators. Depending upon the site, some hosts are mental health professionals who may be licensed or unlicensed, whereas other hosts have no mental health training at all. There are no uniform standards or requirements for hosts (as is also true for some face-to-face support groups). Consequently, cyber counseling or "E-counseling," is not permitted. Instead, hosts function as resource persons rather than online counselors. They make referrals to telephone help-lines, self-help resources, clergy, face-to-face support or self-help groups, local counseling centers, crisis centers, acupuncturists, and hospice centers, among other resources. They also recommend links to other online support and self-help groups (e.g., see Table 1), to resources worldwide (e.g., www.na.org, Narcotics Anonymous worldwide services), to mental health Web sites (e.g., www.psychwww.com), to self-help Web sites (e.g., www.800gambler.org), and to professionally oriented counseling Web sites (e.g., Journal of Online Behavior at www.behavior.net/JOB).

Moderators also ensure that communication remains focused on the topic and that ground rules (i.e., remain anonymous, take turns, remain focused on the topic, abstain from harassment [e.g., personal criticism, cursing, or name-calling], and maintain confidentiality) are enforced. Violators of the ground rules can be sanctioned. Each ISP, portal, or Web site maintains a "terms of service" contract that outlines appropriate online behavior, explains how violations are handled and metes out sanctions. For example, the Alcoholics Anonymous (*www.aa-intergroup.org*) home page features "netiquette," which describes appropriate online behavior. At other sites, the host may have the technical capability to block out inappropriate comments from a specific violator for a brief or indefinite period of time and may be able to send private warnings through an instant messenger feature.

Prior to each session, the host may select a predetermined session topic designed to promote intimate dialogue and self-disclosure. The host might plan to discuss mourning or missing loved ones during an approaching holiday, for example. At times though, members' needs may differ from a host's preselected topic, and the host must be flexible to meet the group's immediate needs.

The screening and training of moderators is important to facilitating basic helping skills and referral skills (Sampson, Kolodinsky, & Greeno, 1997). Prospective moderators can be screened online to determine their interpersonal skills and their ability to facilitate group discussion. Once selected, moderators are typically trained online using a distance learning model of training. For example, America Online trains hosts through a "Virtual Leaders Academy" and "Community Leaders College." AOL's training modules are focused, for example, on the role of the host, referral skills, crisis management skills, appropriate online behavior, computer literacy, enforcement of the terms of service agreement, and online facilitation skills (i.e., encourage group participation and maintain order in cyberspace). Training occurs online, is completed on an individual basis and follows a prescribed and sequential order of courses. Each course takes 2 to

3 hours to complete and concludes with an examination. AOL requires continuing education online every 6 months, which is monitored by a training coordinator. At some sites, experienced hosts may mentor newly trained moderators.

BENEFITS OF ONLINE SUPPORT GROUPS

Before describing the benefits and limitations of online support groups, readers should note that nearly every perceived benefit by some is a perceived limitation by others. Personal circumstances, cultural and personal values, and access to computer technology influence one's perception of a benefit or a limitation.

Increased Access to Support

Online support groups provide support and camaraderie to people for many reasons, at a convenient time, and in different ways. They enable people to seek support from a wide variety of perspectives when feeling vulnerable, to reduce the sense of isolation, and to increase their access to support services if and when support is not available in their local community (Grohol, 2000). Internet access at a library, computer center, after-school program, or community center enables people who cannot afford to purchase a computer to participate online as an equal member without financial resources becoming a barrier (Lee, 2000).

Members focus exclusively on pertinent needs and issues rather than on distracters such as physical attributes, linguistic accents, or social status because members are faceless, genderless, raceless, religionless, ageless, and classless, unless they choose to disclose such personal information. The absence of distracters reduces some of the prejudices and barriers that limit social interaction based on demographic and personal characteristics (Bowman & Bowman, 1998). For instance, the absence of physical attributes enables a Jewish or African American man and a Klansman to support each other and develop a relationship in cyberspace but the same support and relationship would most likely never occur face-to-face.

Adjunct to Counseling

Online support groups can function as an effective therapeutic adjunct to counseling for members who require more support or more frequency than individual or group counseling provide (Grohol, 2000). An online support group member can join several online support groups between counseling sessions and seek the level of support needed without overburdening a counselor or overwhelming group members and the leader or leaders. Grohol listed 161 online support groups and 132 newsgroups. An additional benefit of online support groups is the lack of expense to participate in comparison to the expense of counseling and membership fees of face-to-face support groups.

Therapeutic Factors

Members of online support groups benefit from Yalom's (1995) therapeutic factors. For example, universality unites people as they share similar thoughts, feelings, fears, and reactions with their cyber group. Others struggle too; this is not always evident to an emotionally distressed person who often wallows in isolation. As people share and support others, they realize that distress is a part of life, they feel validated, and they heal as they learn to cope from others.

Specialized Online Support Groups

Online support groups dedicated to specific topics, age groups, or gender groups can be formed more successfully in comparison to face-to-face support groups that are limited by geography. Furthermore, some online support groups are marketed as age specific, gender specific, or both to attract members, accommodate cultural mores, or focus on specific needs. Young adults, for example, may benefit from age-specific online support groups to discuss substance abuse. They may be uncomfortable seeking help from adults or unable to relate to adult issues of substance abuse. Likewise, gender-specific online support groups may support women concerned about eating disorders or support men as they develop skills to reduce violence against women. Most importantly though, specialized online support groups connect people who need someone with whom they can communicate honestly and openly, thereby increasing their ability to cope with their distress.

Privacy

Online support groups give members the privacy to seek support and information about behavior that might be perceived as a stigma, and the fear of exposure can become a barrier to obtaining services, support, or information. Further, one's social status in the community might be jeopardized and thus inhibit participation in a face-to-face support group. Privacy and anonymity protect members' identity and family name

and help members to overcome some of the social and cultural barriers without fearing ridicule, cultural stigmatization, or vulnerability within the community (Day & Schneider, 2000; Wu, 1999). From the privacy of one's home, library, after-school program, or community center, a member can overcome these social barriers and be supported, informed, and self-disclosing, yet not fear ridicule, cultural stigmatization, or vulnerability within one's geographic community (Day & Schneider; Nickelson, 1997; Sussman, 1998).

Although privacy facilitates communication for some online group members, privacy should not be taken for granted. As an example, privacy in the workplace may be compromised because the employer may be legally entitled to monitor computer activity and transmissions (Hughes, 2000). To maintain privacy, a member should minimize self-disclosure in online support groups on an employer's computer, during the lunch hour or after business hours, for instance.

The sharing of computers raises other privacy issues when the member is known within a circle of employees or in a household. If employees share a business computer, other employees may be able to read newsgroup messages or transcripts from the support group. Moreover, one computer per household is common. If a computer is shared with family members, they too may be able to read private messages or transcripts. Members using a shared computer should join online support groups that require a password to participate.

LIMITATIONS OF ONLINE SUPPORT GROUPS

Differing Stages of Group Development

Most online support groups are open continuously to new membership. In addition to new members joining an established group, other online members may log on or log off at any time during a session. Such fluctuations in membership make it difficult for online support groups to engage in the typical group phases of warm-up, action, and closure (Hulse-Killacky, Kraus, & Schumacher, 1999) or to maintain the working stage of group development for extended periods (Corey, 2000). This limitation reduces the efficacy of online support groups as a sole support source for some members and may warrant their role as adjunctive support within a comprehensive counseling plan.

Research participants who are members of online support groups tend to experience the working stage of group development (Meier, 1997). However, research designs do not mimic real-world conditions and researchers limit participation by topic, occupation, age, and number and type of participants, among other variables. For instance, Meier evaluated an asynchronous online stress management support group for social workers. She observed that over time, the structural complexity of subjects' messages increased, tended to be longer, and addressed many issues as subjects' experienced group cohesion and the working stages of group development (Corey, 2000; Yalom, 1995).

Limited Feedback

Online support groups enable members to "hide" emotionally and interpersonally behind computer screens (Sampson et al., 1997; Spinney, 1995; Sussman, 1998). The lack of face-to-face contact obscures vocal intonations and verbal and nonverbal cues, including body language and expressions of emotion. Limited feedback may require changes in a member's habitual patterns of interaction and thinking in order to overcome this limitation (Day & Schneider, 2000). Dissatisfied members typically cite limited feedback as a disincentive to participate (Galinsky et al., 1996).

Although a member may initially feel uncomfortable with limited emotional and visual feedback, such limitations may, in time, be overcome. Those members with interpersonal difficulties may perceive limited feedback, reduced interpersonal intimacy, and decreased emotional intensity as incentives to participate. They may not feel pressured to take personal and interpersonal risks as they might experience in face-to-face support groups where their identity is known (Casey, 2000; Weinberg, Schmale, et al., 1995). The lack of interpersonal pressure, coupled with the ability to participate gradually at one's own comfort level and the freedom to offer honest feedback without feeling inhibited or embarrassed, may increase members' self-confidence as they self-disclose, become assertive, set boundaries, and support others at their own pace (Lee, 2000).

Crisis Management

The successful resolution of an emotional crisis in cyberspace is a challenge. Limited feedback and lack of sufficient information make an immediate crisis referral difficult, especially when the host may not know members' geographic locations and current use of local resources or when the host is unable to recommend local resources. The following situations further complicate resolving a crisis or can exacerbate one: (a)

premature disconnection from the online support group at a crucial moment or to avoid an uncomfortable issue, (b) personal emotional baggage that tends to reduce resiliency (e.g., previous psychiatric hospitalizations), (c) reluctance to fully self-disclose information relevant to the crisis, (d) lack of verbal and nonverbal cues, and (e) inability to make a referral to a local crisis center, hospital, or other mental health facility (Sampson et al., 1997; Sussman, 1998).

Crisis referral in cyberspace may necessitate that the host instruct the member to disconnect from the online support group and use the telephone to seek local assistance by dialing 9-1-1 if the member resides in the United States. Other alternatives include a referral to a local crisis center if the member is willing to initiate face-to-face contact or a referral to a 24-hour help-line if the member requests anonymity.

Anonymity Breaches

Steps are taken to maintain the anonymity of each member as well as the confidentiality of group dialogue. Hosts promote anonymity by discouraging the exchange of identifying information; further, they send referral and other requested information to a member's E-mail address rather than to a residence. Personal communication between members without a host facilitating is discouraged. Personal communication can culminate in the exchange of identifying information such as an address or place of employment, thus placing a member at risk for physical harm or "cyber stalking."

Moderators must remain abreast of current advances in computer security to ensure members' privacy and anonymity. In spite of computer security procedures, anonymity can be breached and dialogues can be intercepted (Davidson & Jackson, 1997; Lee, 1998; Newman, 1997; Sampson et al., 1997; Sussman, 1998). Members must consider the risk of a breach in anonymity before joining an online support group, must weigh the benefits against the risks when accessing services, and understand limits of confidentiality. Further, they should limit the disclosure of personal and identifying information during the registration and orientation process.

Quality Control

The quality of online support groups varies. Each sets its own standards, procedures, and training programs for hosts. New members are well advised to try several online support groups in search of the best fit. Locating an appropriate online support group may be haphazard because there is no master plan or repository to organize and identify services. Moreover, sites are unreliable for longevity and consistency. They appear, disappear, or are purchased by another site and may change their Web address.

Host or Moderator Competency

Professional degrees and experience (or the lack of) for hosts vary among online support groups. A new member may assume incorrectly that hosts are trained in a mental health discipline. We advocate caveat emptor (i.e., buyer beware) and that new members visit several online support groups and evaluate the facilitation, support, and referral skills of the moderator or moderators.

Limited Language Skills

The rapid pace and simultaneous, text-based dialogues of a real-time online support group may frustrate members with an expressive or receptive learning disability or with language limitations (such as English as a second language). The member with limited language skills may be challenged in communicating feelings and thoughts verbally to others without relying on body language and other nonverbal communication to compensate for any verbal deficits (Day & Schneider, 2000). Conversely, other members may be challenged to respond in a supportive and helpful manner if they are unable to comprehend the member's needs. In real-time text-only communication with limited interpersonal feedback, communicative misunderstandings are common for all members and could be exacerbated for the member or host with limited language skills. If the host suspects a member is struggling to communicate, the host should role model a different level of vocabulary and check with the member periodically to ensure comprehension and accurate expression.

Members with limited language skills may benefit from software programs that convert spoken word to text and vice versa. For example, continuous speech programs enable the member to participate by dictating responses, and speech synthesis programs translate written text from the computer into speech (Sachs, 2001). Members with physical disabilities that limit dexterity such as cerebral palsy, can use similar software programs and participate in online support groups.

Ethical and Legal Concerns

The moderating of and participation in online support groups raises some ethical and legal questions that currently remain unanswered. For example, are online support groups considered a component of cyberspace mental health services as defined by most national and state or provincial statutes, mental health professional associations, and mental health licensing boards? Several mental health professional organizations and licensing boards, including American Counseling Association (ACA), American Psychological Association (APA), and National Board of Certified Counselors (NBCC), are grappling with the ethical and legal issues raised by the gamut of cyberspace mental health services (Bloom, 1997; Bloom & Walz, 2000; Lee, 1998). Jurisdiction is unclear and confusing because cyberspace mental health services function without regard to geographic borders or local, national, or international regulations. This makes legal mechanisms of resolution unsatisfactory for legal liability, dispute resolution, and professional discipline for those hosts who are mental health professionals (Lee, 1998; Spinney, 1995). Comprehensive revisions of mental health statutes and ethical standards will require the coordination of all mental health disciplines and state, federal, and international agencies. The professional organizations and licensing boards must address all components of cyberspace mental health services regarding compliance, enforcement, training, monitoring, and supervision issues for mental health professionals (Bloom; Bloom & Walz; Lee, 1998).

Hoax Perpetration

People with unscrupulous motives can deceive an online support group. Deceptions occur if members communicate distorted or inaccurate information or if they withhold relevant information, such as not disclosing that they are pedophiles or perpetrators of other sexual misconduct. Deceptions are most obvious when a member expresses unbelievable experiences or multiple or horrific losses (however, on occasion, such experiences are truthful), when details are scarce, and when inconsistencies emerge. Members from cultural backgrounds that respect the opinions of others or people who do not confront others, especially strangers, may be vulnerable to deceptions.

An experienced moderator may suspect a ruse but be unable to decipher the truth immediately. The moderator must attempt to protect all members while continuing to support the suspected perpetrator by listening for inconsistencies before confronting and referring the violator to the "Terms of Service" agreement. ISPs, portals, and Web sites typically lack strong consequences to punish the violator, except to limit access to online services.

FUTURE DIRECTIONS

The quality and speed of computer and Internet technology has steadily improved in sophistication and impact. Online support has the potential to grow as long as members and moderators develop a healthy management of state-of-the-art technology tools. Furthermore, moderators should implement technology that maximizes privacy, anonymity, and rapid transmission of exchanges. Some state-of-the-art technology eliminates or reduces some of the technical limitations of online support groups. Internet software such as the Palance or e-mail Voice Link use microphones and speakers to communicate. E-mail Voice Link facilitates verbal conversations and enables members to hear other members' actual voices, including vocal intonations. The Palance (Page et al., 2000; The Palance, 1998) was developed to improve cyberspace group counseling but could be useful in online support groups. It establishes a visual virtual room for group counseling on each member's personal computer screen. The visual arrangement and visual cues help make the "room" intimate and similar to a face-to-face group. A Palance room establishes the pseudoidentity of members, indicates the number and proximity of members, and allows members to change their location or proximity to others, to withdraw temporarily, or to leave the room. Each member uses a pseudonym to maintain anonymity and selects a caricature or an actual photograph for its avatar. Each member observes the movements and reactions of all members or avatars on individual computer screens. Communication is text-based and appears in a cartoon-like balloon above the avatar's head. Sounds (e.g., cheering) and speech synthesis can be incorporated. All members must use the Palance to participate. The group leader can individualize the appearance of the "room." Encryption is used to ensure confidentiality. A virtual door can be locked when maximum group size is attained.

With the addition of a video camera connected to the audio equipment, video teleconferencing enables members to maintain visual and audio contact. Video teleconferencing is the simultaneous transmission and

reception of video and audio across cyberspace. Video teleconferencing encourages natural interaction among members by permitting members and the moderator to observe each other's nonverbal communication as well as hear verbal intonations. Video teleconferencing and the Palance operate in real time.

These technological advances can make online support groups somewhat comparable to face-to-face support groups while avoiding the inconveniences associated with gathering at a geographic location. However, some of the benefits of privacy and anonymity that members currently enjoy and find unique or attractive about online support groups would be compromised to various degrees by the use of state-of-the-art technology. For example, members using video teleconferencing would no longer be visually anonymous or able to disguise their gender, race, or age, but they would use pseudonyms.

Increased use of the Internet has raised interest in new ways of measuring time without the conversion of time zones. The Swatch Group of Switzerland devised *"Internet time"* as a new universal system of time to replace Greenwich Mean Time (GMT) and to facilitate the calculation of time globally (Lockridge, 1999). Internet time facilitates the scheduling of online support groups across time zones by eliminating the need for members to calculate time differences.

In Internet time, the day is divided into 1,000 "beats" per 24-hour cycle and each "beat" is equivalent to 1 minute and 26.4 seconds. The symbol "@" preceding a number corresponds to the time of day between 000 and 999. A day of Internet time begins at @000 Biel Meridian Time (BMT), the Swatch meridian in Biel, Switzerland, where @000 is midnight and @500 is noon. For example, in Biel, 1 a.m., 2 a.m. and 10 p.m. become @041, @083, and @916 respectively in Internet time. Beats do not convert neatly for most hours in the 24-hour cycle as the example illustrates.

One's local time would operate on BMT but @000 might not be midnight. For example, midnight in New York City would be @708, based upon the current time difference with Biel. Thus, if an online support group convenes at @125 for instance, then in New York City, Los Angeles, and Biel, the traditional times would be 8 p.m., 5 p.m., and 3 a.m. respectively although @125 is the Internet time for the three locations. Internet time may appear awkward initially and the average person may be reluctant to convert but Internet time is advantageous when arranging teleconferences and support groups in cyberspace.

Online support groups and self-help groups provide an alternative vehicle of support for people in distress by linking people with similar issues. They have the potential to improve the access and delivery of support to a wide variety of people, including some who would not seek face-to-face support or self-help at all. Finally, they reduce the sense of isolation caused by geographical or physical or medical constraints and increase feelings of validation. However, they are not appropriate for everyone.

Research on the efficacy of online support groups is limited. Additional evaluative research must be twofold. Researchers should identify (and thereby reduce) hazards that might hamper effective online support and self-help, as well as examine the effects of new computer technology, such as video teleconferencing and The Palance, which might maximize helping and communicating online.

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16

Using Thought Listing to Examine Attitudes Toward Homosexuality: A Case Study

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A case study is presented to illustrate the efficacy of using the thought-listing technique for investigating attitudes toward homosexuality. Four women and two men with varying degrees of sexual prejudice were selected from an existing data set. Respondents' scores on the Index of Attitudes Toward Homosexuals (Hudson & Ricketts, 1980) were compared to self-statements obtained in a thought-listing procedure. Results revealed that different categories of responses (cognitive, affective, behavioral) emerged when examining the participants' thoughts regarding homosexuality. The thought-listing procedure uncovers additional information not traditionally obtained from standardized homosexuality attitude scales. Implications for counselors and educators are discussed.

Research on attitudes toward homosexuality has historically focused on the development of reliable and valid scales for measuring attitudes toward people who are lesbian and gay (Herek, 1994). Various measures have been created to assess attitudes toward homosexuality. These measures include but are not limited to the Homosexuality Attitudes Scale (Millham, San Miguel, & Kellogg, 1976), Index of Attitudes Toward Homosexuals (IAH) (Hudson & Ricketts, 1980), Heterosexual Attitudes Toward Homosexuality Scale (Larsen, Reed, & Hoffman, 1980), Anti-Homosexual Scale (Dunbar, Brown, & Amoroso, 1973), Attitude Toward Homosexuality Scale (MacDonald, Huggins, Young, & Swanson, 1973), and the Homophobia Scale (Smith, 1971). An extensive review of the existing homosexuality attitude scales is beyond the scope of this article and others have already discussed the strengths and limitations of these measures (see for example, O'Donohue & Caselles, 1993; Schwanberg, 1993).

Because the IAH (Hudson & Ricketts, 1980) is one of the most frequently cited standardized measures for assessing attitudes toward individuals who are lesbian and gay (Adams, Wright, & Lohr, 1996; Black, Oles, & Moore, 1998; Rudolph, 1989; Serdahely & Ziemba, 1984), it was used in this article and will be briefly reviewed. This 25-item, self-report instrument is easy to administer, and the 5-point Likert-type format allows respondents to rate their degree of agreement with

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statements regarding homosexuality. In addition, the obtained scores allow researchers to quantify attitudes toward homosexuality, examine how attitudes change over time, and compare scores from different samples.

Research that has used these instruments to examine attitudes toward homosexuality was limited by predominately measuring a single attitude construct (i.e., cognitive). Van de Ven, Bornholt, and Bailey (1996) recognized that using only one measurement strategy to assess attitudes toward homosexuality resulted in an incomplete picture of the way sexual prejudice is manifested differently in the thoughts, feelings, and actions of individuals. Some researchers have suggested that a more thorough examination of the affective and cognitive domains is critical to understanding and measuring sexual prejudice (Schwanberg, 1993; Van de Ven et al.). Researchers have recommended that instruments that assess attitudes toward homosexuality retain separate cognitive, affective, and behavioral components because this model best represents current attitude theory (Eagly & Chaiken, 1993).

As stated previously, scale measures of attitudes toward homosexuality can provide a standard score that indicates the level of acceptance or nonacceptance that individuals have toward people who are lesbian and gay. However, the obtained scores do not uncover the thoughts that respondents had as they processed and rated each scale item (O'Donohue & Caselles, 1993). Thought listing has been identified as one method of tapping the cognitive, behavioral, and affective components of attitudes toward homosexuality.

The thought-listing procedure, as discussed by Cacioppo and Petty (1981), has been used as a method of cognitive assessment for measuring and categorizing individuals' immediate thoughts in response to a presented stimulus. In counseling and psychology, thought-listing methodology has been used in the understanding of client thoughts regarding behavioral change and therapeutic interventions (Fuqua, Johnson, Anderson, & Newman, 1984). Thought-listing techniques have also been used to investigate the frequencies and types of self-talk used by group leaders and individual counselors (Hines, Stockton, & Morran, 1995; Morran, Kurpius, & Brack, 1989; Nutt-Williams & Hill, 1996), the role of self-statements in performance of counseling interventions and tasks (Friedlander, Keller, Peca-Baker, & Olk, 1986; Kurpius, Benjamin, & Morran, 1985), and in client responses and conceptualizations of the therapeutic relationship (Heppner, Rosenberg, & Hedgespeth, 1992; Uhlemann, Lee, & Martin, 1994). Only one study has been conducted that examined people's attitudes toward homosexuality by analyzing their self-talk (Guth, Lopez, Clements, & Rojas, 2001).

To illustrate the subtle differences in self-talk that can be obtained by using the thought-listing procedure, this case study extracted information from an existing data set (Guth, Lopez, Clements, & Rojas, 1998) to compare selected participant scores on a standardized sexual prejudice instrument to self-statements obtained in the thought-listing procedure. In this case study, *sexual prejudice* was used to characterize "negative attitudes toward an individual because of her or his sexual orientation" (Herek, 2000, p. 19). Herek (2000) stated that *sexual prejudice* (rather than *homophobia*) is the preferred term to describe negative attitudes toward homosexual behavior and people or communities who are lesbian, gay, and bisexual.

Method

Participants

A portion of data that was collected as part of a broader study on the effects of training in lesbian and gay issues was used (Guth, Lopez, Clements, & Rojas, 1998). Six participants were selected for this case study. These individuals were Caucasian undergraduate psychology students (4 women, 2 men) from a southeastern university. The mean age of the sample was 27 years (range: 20 years–37 years). Regarding sexual orientation, 100% indicated that they were heterosexual.

Instruments

IAH. The IAH (Hudson & Ricketts, 1980) was used to assess attitudes toward homosexuality. Respondents were asked to rate their level of agreement or disagreement with 25 items related to homosexuality. An overall index for the IAH was created by summing the responses to the items. Scores on the IAH could range from 25 to 125. Lower scores on this standardized instrument indicate more accepting and positive attitudes. The IAH has been shown to have high test-retest reliability and good factorial and content validity (Hudson & Ricketts; Pagtolun-An & Clair, 1986; Serdahley & Ziemba, 1984).

Thought-Listing Instrument. In addition, respondents were presented with written situations related to lesbian, gay, and bisexual issues. After each scenario was read aloud to the participants, they were asked to

recall their thoughts and write them in the spaces provided (*Cacioppo and Petty, 1981*).

Procedure

The data used in this case study came from the participants' pretest session. Participants were asked to complete a pretest questionnaire assessing their general beliefs, feelings, and thoughts regarding homosexuality. The questionnaire included the IAH (Hudson & Ricketts, 1980) and a thought-listing instrument.

A purposeful sampling technique (Patton, 1990) was used to select 3 matched pairs of respondents (n = 6) with varying levels of sexual prejudice. Each pair had the same obtained score on the IAH and was chosen to illustrate how thought listing can uncover unique information about attitudes and perceptions that cannot be obtained when using a standardized attitude scale. Their thoughts on the following situation were examined: "You overhear coworkers making degrading comments about homosexuals." For an in-depth description of the systematic thought-listing procedure that was used to identify and define broad thought content categories, see Guth et al., 2001.

Results

The first pair of respondents scored 37 on the IAH indicating accepting attitudes toward homosexuality. However, closer examination of the thoughts revealed some differences in perceptions. The first participant responded to the situation on affective and behavioral levels. For example, this individual expressed feelings such as "annoyed" and indicated a behavior: "Try to make a point with each individually." The second individual responded to the situation on a cognitive level expressing thoughts such as "Pin Heads!" "This is just racism," and, "It is not worth it—you can't change minds about this."

The second pair of participants scored 77 on the IAH indicating an increasing degree of sexual prejudice. This pair produced a mixture of accepting and nonaccepting thoughts. The first participant responded on a behavioral level stating, "Don't get involved," and "Then again I'll probably join/laugh knowing it's not right." The second individual also responded behaviorally stating, "Listen and voice my opinion," and "Tell them everyone has a right to choose."

The third pair of respondents scored 114 on the IAH indicating high levels of sexual prejudice. The first participant responded on a behavioral level stating, "Ignore it," "Mind your own business," and "Join in." The second individual responded on a more cognitive level stating, "Homosexuality is wrong," "Immoral," "Bad, bad, bad," "It's disgusting," and "Unacceptable."

Discussion

As can be seen by these illustrations, the respondents' thoughts about homosexuality fell on a continuum from extremely positive to extremely negative. Overall, the degree of sexual prejudice as measured by the IAH was additionally supported by the thought content. For example, respondents who had scores on the IAH indicating a high degree of sexual prejudice also expressed nonaccepting thoughts.

However, the thought-listing procedure helped to discover subtle differences among respondents who had the same score on the standardized IAH measure. Different categories of responses (cognitive, affective, and behavioral) emerged among the participants; these categories provide illustrations of how people thought about the topic of homosexuality. Although each pair of individuals had identical standard scores, they differed in their personal reactions to the same stimulus situation. Respondents expressed their emotions, cognitions, or behaviors as responses to the situation. Thought listing tapped all three components of the tripartite model for understanding attitudes (Eagly & Chaiken, 1993) and can be a useful tool for exploring the attitudes that individuals hold toward homosexuality.

The information gained from this investigation has implications for counselors and educators. With proper training, counselors and educators can use this methodology as an assessment tool. Furthermore, when dealing with issues of sexual orientation, counselors could use thought listing to explore clients' feelings, thoughts, and behaviors toward homosexuality; assess developmental needs; and uncover counseling issues. In addition, counselors and educators may not be able to use the same type of therapy or training for people who are processing and responding in the different domains. Thus, educators may need to tailor training in lesbian, gay, and bisexual issues to the different typologies that emerge. A rational approach may be more effective for those who process on a cognitive level whereas an experiential approach may be more effective for those who process on an affective level. Clearly, this inference needs further empirical investigation.

In conclusion, this article highlighted a need for additional methods of assessing the cognitive, affective, and behavioral components of attitudes toward homosexuality. The thought-listing methodology appears to be a complementary method for obtaining data not traditionally uncovered by standardized scale scores. The thoughts obtained by this technique provide support for O'Donohue and Caselles' (1993) conceptual model wherein they proposed that reactions toward homosexuality fall into three broad types: emotional, intellectual or cognitive, and behavioral. However, these findings need to be considered in light of the limited sample size that was used. Future research could extend this investigation by using a larger, randomly selected sample of students. This would increase the generalizability of the findings.

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Gender and Ethnicity in Identity Formation

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Identity formation among ethnic minorities is becoming a highly important area of study in light of North America's rapidly changing demographic landscape. As ethnic minorities integrate into American society, balancing their minority culture with mainstream American culture becomes an important task in identity development. It becomes an even more complex process when gender is added to the scenario. This article suggests that it is the interaction of gender and ethnicity-not each factor in isolation-that profoundly affects identity formation. To support this assertion, this review of literature presents (a) an overview of research on gender and ethnic socialization, (b) a synthesis of research on gender and ethnicity in identity formation, and (c) practical implications for counselors.

Ego identity formation is a central developmental task during the period of adolescence (Erikson, 1968). The adolescent years are typically marked by the exploration of different roles and lifestyles in an attempt to find a right fit. As individuals experience life more fully, their decision-making process culminates into a crystallized sense of self. Identity provides the structure for personality, equipping the individual with a sense of purpose and direction for one's life. Ego identity exploration is common to all adolescents. However, it is particularly complex for members of ethnic minority groups (Markstrom-Adams & Spencer, 1994).

Although numerous researchers have studied the role of varying components of self (e.g., religious and political orientation) in identity formation (e.g., Marcia, 1966), surprisingly few researchers have explored the important role that ethnicity plays in identity. Phinney and Rosenthal (1992) have noted that more research needs to be conducted examining the impact of ethnicity on identity. They reasoned that racial and ethnic minorities have an added dimension to their identity development. These youth are faced with the challenge of not only developing their personal identity, but also integrating their identity as an ethnic group member with their identity as an American. In short, they must negotiate between multiple identities. Dubois (1903/1969) captured this sentiment when he described the African American identity: "One ever feels his two-ness,-an American, a Negro; two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body" (p. 5). This sense of "two—ness" seemingly contradicts Erikson's (1950) developmental goal of Ego Integrity (i.e., "oneness"), again suggesting how profoundly ethnicity has been neglected in identity research.

The impact of gender on identity development, in contrast, has received much attention in the psychological research (e.g., Skoe & Marcia, 1991). The impact of differential socialization by parents influences the way that boys and girls perceive themselves as well as their external realities. Such a view of socialization could easily apply to ethnicity's effect on identity development and would provide a logical bridge between the two factors, yet few researchers have examined the impact of both gender and ethnicity on identity development (Phinney, 1990).

As such, for this review the author examined the existing research on gender and ethnicity in identity formation. This review certainly is not intended to be a comprehensive work, but rather seeks to integrate

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existing research in these three areas to encourage a more holistic view of identity development. Implications for counseling are presented.

Socialization Processes

Gender Socialization

Numerous studies have suggested that parents view their children through the lens of gender schema (Karraker, Vogel, & Lake, 1995). These perceptions have significant effects upon the identity development of males and females. Researchers have suggested that identity development is constructed primarily through the relationships in which one has engaged (Marcia, 1993). Therefore, gender socialization establishes the identity structure, at least in part, for the individual. Although some scholars have suggested that biological factors influence one's gender formation, Marcia (1993) pointed out that "being a biological male or female [is] less important in understanding adult relationships than [are] one's beliefs and values about their maleness and femaleness" (p. 107). These beliefs about gender orientation may be directly related to the degree to which parents adhere to gender schema.

According to the literature, socialization processes related to gender orientation start at an early age (Maccoby, 1992). From birth, according to some studies, parents project expectations of gender-specific behavior toward their children (Condry & Condry, 1976; Hoffman & Kloska, 1995; Rubin, Provenzano, & Luria, 1974). Although all babies behave in a similar fashion, adults tend to define their behaviors, often unconsciously, in terms of distinctly different gender stereotypes (Hoffman & Kloska). In two studies that employed similar methodologies, Rubin et al. and Karraker et al. (1995) interviewed parents of newborn babies that were 24 hours old. When the parents from both studies were asked to describe their babies, the parents of girls reported that their babies were softer, more delicate, and finely featured. The parents of males described boys as stronger, larger, and more masculine. Although these studies were conducted almost 20 years apart from each other, they both revealed that gender stereotype perceptions continue to persist. Apparently, in ambiguous situations in which gender differences in behavior should not be detected, stereotypic assessment becomes salient.

As identity begins to crystallize in adolescence, salient differences between the two genders emerge. First, studies indicate that the relational (interpersonal) social processes are more closely linked to the conceptual framework of female identity development compared to males who have been found to be more self-oriented (intrapersonal) (Adams & Jones, 1983; Fannin, 1979; Grotevant & Thorbeck, 1982; Kroger, 1988). Archer (1989) contended that females are more likely to develop sophisticated identity statuses in the area of family and sexuality priorities (domains related to intimacy). Female identity development revolves around who she can be in relation to others. Specifically, she faces the issue of what it means to be a woman in society and in relation to others. Moreover, a woman's sense of self is contingent upon her successfully resolving issues of connecting with others in ways that satisfy herself as well as those in her communal context (Archer, 1993).

In contrast, male identity development rests on the capacity to master and handle nonsocial realities, in which his talents and interests are directed toward achieving a sense of personal competence (Archer, 1993; Skoe & Marcia, 1991). Archer (1993) noted that male identity development is a matter of separating oneself for action to defend against domination by others. She suggested that males are socialized to develop skills and talents to be competitive in the workplace. This ideology conveys the impression that the world of work is not people oriented and that men don't need to be interpersonal. Other research has rendered similar findings. Investigating the relationship between moral reasoning and identity, Skoe and Marcia found that men were likely to uphold a justice-based moral reasoning that espouses a principle-oriented, nonpersonal view of right and wrong. Women, on the other hand, demonstrated a care-based moral reasoning. The idea of care-based moral thought is rooted in Gilligan's (1982) theory of moral development, which suggests that a woman's conception of self and morality are complexly associated.

A second prominent difference between male and female identity development is that because of sociocultural expectations of women (e.g., balancing occupation and caregiving), identity development may be a longer process for females compared to males (Marcia, 1980,1987). Archer (1985) attributed the intricacy of female identity development to the high number of content domains used to define "womanhood," coupled with the relative lack of societal support for the female position.

Research suggests that the general period for identity formation among males is between the ages of 18

and 22, but Kroger (1987) found that female subjects were predominantly in the moratorium stage from the ages of 17 to 47. Patterson, Sochting, and Marcia (1992) suggested that for the majority of women, the task of developing a sense of identity may be prolonged until the departure of their children. For it is at this time that they have the opportunity to freely pursue their identity commitments.

Ethnic Socialization

As the number of minorities in the United States increase, the socialization of ethnic minorities has become a topic of growing importance. Three themes emerge in the literature regarding ethnic socialization: (a) the need to be socialized to one's own culture, (b) the need to be socialized to mainstream society, and (c) the need to understand prejudice and discrimination (Phinney & Chavira, 1995; Rosenthal & Cichello, 1986).

First, learning one's own culture is a prominent aspect of ethnic socialization. It is not clear, however, exactly how this process is achieved across all ethnic lines. One might assume that the mere observation of parents' behavior at home would provide children with a natural learning environment about their culture. Research seems to indicate that these learning processes may vary in priority among different ethnic groups. Phinney and Chavira (1995) discovered that African American parents were found to provide the most extensive ethnic socialization among three ethnic groups (African Americans, Japanese Americans, and Mexican Americans). According to Bowman and Howard (1985), a significant number of African American participants reported that their parents taught them about African history, culture, ethnic pride, and commitment to the African American community. Likewise, Thornton, Chatters, Taylor, and Allen (1990) reported that approximately 30% of African American subjects were taught the historical traditions of African Americans as well as ethnic pride. Last, a study with young African American children and their parents revealed that children with a high sense of ethnic awareness and knowledge tended to have parents who taught them positive aspects of their ethnic background (Branch & Newcombe, 1986).

As noted, ethnic socialization differs among ethnic groups. According to Phinney and Chavira (1995), Asian American participants of Japanese descent were least likely in comparison to African American and Mexican American parents to ethnically socialize their children. Indeed, data on Asian American socialization processes have revealed that most Asian parents exhibit very little verbal teaching about Asian culture and traditions (Chae, 2000). Rather, nonverbal routines lay a foundation for modeling expected behavior (Hieshima & Schneider, 1994).

Second, different ethnic groups have been found to spend more time socializing children toward "getting along" in mainstream society. Phinney and Chavira (1995) found that Asian American parents were most likely compared to African American and Mexican American parents to encourage their children to be successful academically and to ascribe to American ideals. Likewise, in a study measuring the degree to which ethnic groups identify with the ideals of North American culture, Phinney, DuPont, Espinosa, Revil, and Sanders (1994) found that among four ethnic groups (i.e., African Americans, Asian Americans, Latino Americans, and White Americans), Asian Americans were most likely to identify with American cultural values such as individualism and self-sufficiency. Furthermore, large portions of Asian American participants were highly assimilated into mainstream American society. This assimilation may be one of the reasons why Asian Americans have been deemed the model minority. However, assimilation and its correlative rewards may be attained at the cost of losing one's ethnic identity. Researchers have noted that Asian American participants were most likely to indicate that they did not like their ethnic identity, and if given the opportunity, would be Caucasian (Phinney & Chavira, 1992).

Research on African Americans has revealed more of a bicultural orientation. Demo and Hughes (1990) have suggested that African American parents were most likely to balance a sense of ethnic pride with a desire (perhaps a need or duty) to get along with White Americans. Cross (1987) suggested that African American parents teach their children to become bicultural as a means of achieving acceptance by both minority in-group culture and dominant (and presumably hostile) majority culture.

A third component of ethnic socialization entails the preparation for discrimination and prejudice. Adolescents from ethnic minority groups will be forced to confront issues of prejudice, discrimination, and structural (i.e., institutional) barriers against opportunity (Carter, 1995; Phinney, 1992). Again, the research indicates differences among ethnic groups. Phinney and Tarver (1988), in a qualitative analysis of

structured interviews revealed that African American adolescents, compared to White Americans, had a better understanding of prejudice and discrimination toward their own ethnic group. Further, Demo and Hughes (1990) described African American socialization as teaching children to become aware of institutional and cultural barriers that exist in society. Research on Asian Americans has shown that parents socialize their children to excel academically as a means to upward mobility (Sue & Sue, 1999). In general, Asian American parents provide little teaching about racism and discrimination.

Gender, Ethnicity and Identity: A Synthesis

Gender and ethnic socialization processes lay the groundwork for identity development. Ecological factors play an important role in shaping the identity development for ethnic minorities. The way that a group is perceived by majority society and the sociocultural expectations of the group itself influences the way the individual group member processes his or her identity (Tajfel, 1982). The majority of existing research focuses on African Americans. Therefore, sweeping generalizations that include other ethnic minority groups would be difficult to make.

Research suggests significant differences between male and female identity development among ethnic minorities (Bowman & Howard, 1985; Phinney, 1990; Wade, 1994). Evidence suggests that males develop an awareness of ethnic obstacles and seek equality to majority society group members, whereas women are more likely to develop strong ties to ethnic heritage and tradition. Bowman and Howard found that African American males were more oriented toward equality and institutional barriers, whereas their female counterparts were more likely to be oriented toward ethnic pride and adherence to their cultural background. Likewise, Wade suggested that ethnic minority men are socialized to develop a deep awareness of ethnic barriers and may develop a compensatory sense of exaggerated masculinity characterized by sexist attitudes, antifemininity, and aggressive solutions to disputes. Spencer, Cunningham, and Swanson (1995) added to this dialogue an interesting perspective, linking African American child-rearing strategies with what they refer to as "hypermasculinity." The authors wrote, "The parental use of contempt and humiliation to socialize the emotions of fear and distress in boys is hypothesized to be of major importance in fostering an exaggerated masculine style" (p. 37). These gender differences are further supported by lower scores in identity statuses of African American men as compared to their female counterparts. Parham and Helms (1985) found that African American males were more likely to have preencounter attitudes compared to their female counterparts, who were found to score significantly on inner-directedness, a manifestation of higher identity functioning. Similarly, Carter, DeSole, Sicalides, Glass, and Tyler (1997) found that African American men scored high on the preencounter status, suggesting that they had internalized American cultural values. Conversely, African American women demonstrated more advanced racial identity statuses, expressing a strong commitment and appreciation of their racial heritage. Phinney and Tarver (1988) found that African American women were more likely to explore their ethnic background and tradition compared to their male counterparts. However, the sample consisted of only 48 participants (i.e., 24 African Americans and 24 White Americans). Finally, Phinney (1989) observed a similar trend in her African American participants: 5 females had an achieved identity whereas none of males had.

In evaluating these findings, the lower identity scores of male participants may be attributed to a reaction formation (Freud, 1933/1965) against the discrimination and racism experienced by this group. Males, in general, have been found to be competitive and task oriented (Spence, Helmreich, & Stapp, 1975). When African American males become aware of out-group prejudice, prominent racial barriers, and inequality, they may feel compelled to seek relief against these threats to their male sense of efficacy in egalitarianism. Their male socialization, which emphasizes a sense of dominance, may be undermined by sociopolitical barriers, causing them to fall short of the "traditional male gender role." Moreover, one of the primary tenets of moral thought for men is justice and equality (Skoe & Marcia, 1991). Perhaps the masculine — as opposed to the strictly ethnic — socialization process predisposes African American men to be oriented toward equality. Conversely, because females in general may be less competitive (Spence et al.), they may be less concerned with equality and more concerned with interpersonal harmony. Hence, in response to racism and discrimination, African American females may be more likely to maintain a strong adherence to their ethnic background and develop a sense of ethnic pride.

Implications for Counseling

Recently, the counseling profession has recognized the significance of multicultural competency in counseling and psychotherapy (Ivey, Ivey, & Simek-Morgan, 1997; Pope-Davis & Coleman, 1997; Sue & Sue, 1999). Culturally sensitive approaches to helping constitute not only a more humanitarian approach to counseling, but more importantly, a means to improve the overall delivery of mental health services.

As counselors work with multicultural populations, it is important to develop an awareness of one's own culturally learned values, assumptions, and expectations that influence one's behavior and provide meaning to experience (Cheng, Chae, & Gunn, 1998). Sue, Ivey, and Pedersen (1996) recommended that counselors engage in an in-depth exploration of themselves through studying their ethnic heritage, personal history, and genogram. Counselors may learn that much of what they considered as individual characteristics are actually based on traditions and beliefs handed down through culture and family. As individuals begin to see themselves from a self-in-context perspective, they may realize that their own point of view is only one of many possible alternatives.

Culturally sensitive counselors have a knowledge and understanding of the client's minority culture. This knowledge involves developing an understanding of the client and her or his experiences, worldview, and philosophy of life. As research has shown, many racial and ethnic minorities may "hold collectivist or group-oriented values." Therefore, understanding how the client perceives her or his place in American culture is important in facilitating the therapeutic process.

Assessing the client's level of ethnic consciousness provides the counselor with a guide to how the client deals with issues related to her or his ethnic background. In discussing issues related to gender and ethnicity in identity, counselors should recognize that ethnic minority clients may vary in degree of ethnic identity development. Ethnic identity deals with whether and to what degree an individual has explored the meaning of her or his ethnicity (e.g., cultural values) and developed a sense of commitment to her or his ethnic heritage (Phinney, 1996).

Assessing the client's ethnic identity through a framework such as Phinney's (1992) Multigroup Ethnic Identity Measure may be useful. In her framework, she identifies three content domains of ethnic identity: affirmation of belonging, ethnic behaviors and practices, and ethnic identity commitment and achievement. The model assumes that individuals operate on a continuum of ethnic identity formation, with one end representing a weak or uncommitted ethnic identity and at the other end, a strong or committed ethnic identity (Phinney, 1993). Although assessing where the client is in relation to this continuum may be helpful, examining the specific domains in which the client shows evidence of resistance or openness to exploration and commitment is also important. For example, a client may be immersed in ethnic behaviors and practices without having considered what it means to belong to that certain group. This client may have blindly accepted group expectations without questioning the ideological assumptions and beliefs that are associated with group membership. Counselors who can explore and identify these issues may help their clients develop a deeper awareness and understanding of their own ethnic group membership and therefore facilitate the process of ethnic identity formation.

An exploration of social oppression in the form of racism and sexism may also be an important task in counseling ethnic minority clients. Ethnic minority men and women may react differently to sociopolitical barriers. Research has shown that in general, women may develop strong ties and bonds to their ethnic heritage, whereas men may adapt to societal norms by developing an exaggerated masculine style and employing aggressive solutions to disputes. Although providing an open environment to discuss these identity issues is important, the counselor and client's search for resolutions may also be important.

In sum, counselors need to be sensitive to the different cultural values and traditions held by racial and ethnic minorities. Further, understanding the experiences of minority groups in light of North America's cultural context may be valuable knowledge that can help the counselor more accurately conceptualize the client's issues. Although research has shown general tendencies in identity formation among persons of color, counselors should use this information only as a hypothesis that may or may not be confirmed by a specific client's experiences.

Conclusion

Identity formation among ethnic minorities is becoming a highly important area of study as the United States becomes increasingly multicultural. As ethnic minorities become exposed to the traditions of American society, balancing their minority culture with mainstream American culture becomes an impor-

tant task in identity development. It becomes an even more complex process of identity development when gender is an additional variable. The degree to which these sociocultural constructs influence each other is unclear, but this exploration suggests that the interaction—not each factor in isolation—profoundly shapes identity formation. The powerful effects of gender socialization were already evident. The gender role expectations also seem to pervade ethnic lines. Further, ethnic groups seem to socialize children somewhat differently. In part, this differential socialization may be a result of the higher levels of discrimination and devaluation experienced by ethnic groups. Because few studies have been focused on socialization and identity, the author could not review a range of ethnic groups and their socialization practices. In sum, the interaction of gender and ethnic socialization powerfully affects identity development and promotes differential reactions to majority prejudice.

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Acculturation Conflicts Among Asian Americans: Implications for Practice

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This article is an overview of issues that Asian Americans encounter as they acculturate into American society. Counselors who develop knowledge and understanding about the experiences of Asian Americans may improve the overall delivery of counseling services to this population. Topics discussed herein include: (a) negotiating Asian family socialization processes, (b) dealing with the cultural value of shame, (c) exploring one's ethnic identity, and (d) dealing with the myth of the "model minority." As individuals negotiate and explore issues related to cultural transitions, they may arrive at one of four acculturation outcomes: separated, marginal, integrated, or assimilated. Implications for counseling are discussed.

Asian Americans may experience a number of acculturation conflicts as they become more exposed to the traditions, values, and norms of majority society. These individuals are faced with the challenge of resolving primary issues related to the existence of two differing worldviews—those of their own culture and those of the dominant culture—which may impact individuals to varying degrees. Currently, there are at least two theoretical perspectives of acculturation (Abe-Kim, Okazaki, & Goto, 2001; Liu, Pope-Davis, Nevitt, & Toporek, 1999). In one view, acculturation is identified on a continuum of low to high assimilation (Suinn, Khoo, & Ahuna, 1995), whereas the other is based upon a complex and nonlinear model, emphasizing ethnic pluralism (Laroche, Kim, Hui, & Joy, 1996). Given the complexity associated with negotiating between two differing cultures, the perspective of the second model seems more appropriate for a discussion of the cultural conflicts that Asian Americans experience.

According to this two-dimensional framework, acculturation refers to the transitions that occur as a function of continuous contact between two different cultures (Berry, 1991, 1998). The two important issues to negotiate are the importance that the individual assigns to identifying with the minority culture and the importance that he or she assigns to identifying with majority culture.

Upon negotiating these issues, the ethnic minority individual may interact within a multicultural society in one of four ways (Berry, 1991, 1998; Kitano, 1989; Kitano & Maki, 1996). Type A (assimilation) is the outcome when an individual chooses to identify with mainstream culture and to reject the minority culture. Type B (integration) characterizes the individual who seeks to retain her or his own ethnic culture and concomitantly incorporate and adapt to the dominant culture. Type C (separation) involves the identification with the ethnic culture while rejecting majority society norms and values. Last, type D (marginality) is the lack of involvement and identification with one's ethnic culture as well as dominant society.

As Asian Americans explore and resolve issues related to cultural conflicts, they may deal with issues related to traditional Asian socialization processes (Kim, 1994; Yee, Huang, & Lew, 1998), the salience of shame in Asian culture (D. Sue, 1998; Wang & Marsh, 1992), ethnic identity development (Iwamasa & Yamada, 2001; Sodowsky, Kwan, & Pannu, 1995; Min

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& Park, 1999), and conflicts related to the "model minority" label (Lee, 1996; D. W. Sue, 1994). Counselors who gain a deeper understanding of how Asian Americans deal with acculturation conflicts may be better equipped to offer counseling services to clients from this population.

FAMILY SYSTEM, SOCIALIZATION PROCESSES, AND THE SCHOOL

Child-rearing strategies differ across cultures (Deater-Deckard, Dodge, Bates, & Pettit, 1996; Kelley, Power, & Wimbush, 1992). Yet, many mental health professionals and social policy advocates continue to espouse the view that "models of child rearing developed on majorities [should be] used as standards in evaluating minority parenting practices" (Kelley et al., 1992, p. 573). This approach is problematic because such culturally different parenting styles have been interpreted as deficits.

The collective nature of Asian cultural values fosters interdependence among family members. Within these families, the needs and goals of the individual are sacrificed for the attainment of collective interests. Child-rearing strategies are geared toward emphasizing limited psychological boundaries between mother and child. Whereas conventional theories of development suggest that separation is imperative for psychological health (Mahler, 1968), Asian culture and tradition have taught that the interrelatedness between people promotes psychological well-being. Indeed, parents develop close bonds with their children in early childhood and maintain their attachments throughout adolescence. Kim (1994) contended that Asian American parents often consider their children as extensions of themselves. This notion was well illustrated in *The Joy Luck Club*, where Tan (1989) portrayed a mother as sharing credit for her daughter's special talent in chess. She wrote,

> And my mother loved to show me off, like one of my many trophies she polished. She used to discuss my games as if she had devised the strategies. I hated the way she tried to take all the credit. (p. 170)

This type of behavior is common among Asian parents because they "fulfill their own dreams and goals vicariously through their children" (Kim, p. 35). Attaining this gratification through their offspring is an important aspect of parenthood in Asian cultures.

Researchers concurred that Asian socialization techniques promote an interdependent relationship between the mother and child beyond the pre-oedipal years (Azuma, 1986; Ho, 1986; Kim & Chun, 1994; Yee et al., 1998). According to Azuma, Japanese mothers may foster symbiotic relationships with their children to prepare the child for adult life, where she or he can transfer that trust and dependence onto others in the community, particularly teachers (Kim & Chun). Kim and Chun noted that, "In East Asian cultures, the relationship between teachers and their students is seen as an extension of the mother-child relationship" (p. 331). As in the home environment, where children please and obey their mothers, students may be motivated to please and obey their teachers. The Asian school environment is nurturing and maternal, but it also pressures students to achieve academic excellence. As Asians immigrate to the United States, they may assume that the American educational system will take on a similar role as their Asian counterparts.

Unknowledgeable about American schools, Asian parents may bestow the educational responsibilities to the school and their authorities. Consequently, they may devote little time and energy to their children's education. Huang (1994) noted that high school teachers and staff members have criticized many Asian parents because they appeared to lack interest in their children's education. Indeed, the National Coalition of Advocates for Students (1988) has voiced their concerns about the cultural conflicts that evolved with Asian parents and the school system. They noted that schools often labeled Asian parents as apathetic and uninvolved. Conversely, Asian parents also expressed their disappointment because they viewed the American school system as unconcerned and unresponsive. Huang suggested that these cultural situations point to the need for schools to reach out and become accountable to culturally different students and families.

Park (1997) described the cultural conflicts that often exist between first-generation Asians, their second-generation children, and the school system. She pointed out that many Asian immigrants have difficulty speaking English and therefore may be unable to effectively communicate with those in the dominant culture, such as school administrators. At home, children are expected to speak in their native tongue and demonstrate obedience to their parents. However, at school they are expected to be assertive and independent. In some cases, frustrations over these contradictory expectations, combined with difficulties with blending in at school, can cause adolescents to feel alienat-

ed and marginalized at home and in school (Chae, 2001). One 19-year-old male expressed his feelings of not belonging to either the Chinese or American culture:

> I am not Chinese. I looked Chinese but I wasn't really. Starting in elementary school, I began to feel the obvious difference between myself and the other students, who were . . . mostly White. It was then I began to feel very lonely; [with] my classmates because I didn't look like them; [with] my own race, because I was not what I looked like. (Ying & Lee, 1999, p. 200)

CULTURAL VALUE OF SHAME

Traditional Asian families place considerable emphasis on bringing honor to the family name and avoiding shame. A personal achievement brings honor not only to the individual but also to the family and generations beyond (Hsu, 1981; D. Sue, 1998). According to Wang and Marsh (1992), "Differing profoundly from the Western tradition, the Asian family exists as an extended unit connecting the family with present, past, and future generations" (p. 84). Because the family name is so important, Asians may feel compelled to avoid any behavior that could potentially bring shame to their family. This cultural value is deeply infused within Asian socialization techniques. For example, Toupin (1980) suggested that the language often used with children supports the importance of avoiding shame. The term *ha zu ka ski*, in Japanese, means "others will laugh at you." The word *others* is emphasized to denote that their perceptions can bring shame to the entire family. Likewise, Pye (1968) stated, "A child is made hypersensitive to the judgment of ethics, to look to social situations for cues to guide his own actions and to be cautious about initiatives and innovations" (p. 82). Children are reared to behave appropriately and tactfully for every situation. They are encouraged to blend in with the group and discouraged from standing out in any way (Chae, 2001). This sentiment is echoed in an ancient Japanese proverb: "The nail that stands out gets pounded down" (Markus & Kitayama, 1991, p. 224).

Although in Asian cultures avoiding shame is an important aspect of everyday living, the notion of avoiding shame may be considered weakness of character or psychological immaturity from the lens of U.S. cultural patterns (D. W. Sue & Sue, 1999). Western thought emphasizes the importance of being one's own person or not caring about what others think. However, in Asian cultures, harmony with the collective is important, and therefore, how "others" view a person is central to that person's identity.

To avoid bringing shame upon the family, Asians may refrain from being overly expressive or talkative. Speaking too much in a social context is considered shameful because it disrupts group harmony by drawing too much attention to oneself. Being unassertive and inexpressive is considered ideal and is rewarded as such (Wang & Marsh, 1992). For instance, in Japanese schools, one of the most respected achievements is to be named Most Quiet Worker. Lung and Sue (1997) contended that Chinese parents encourage and praise their children for being shy, quiet, and docile. Indeed, silence is considered a sign of wisdom and respect in Asian cultures. The Korean and Japanese terms, *cha ma* and *enryo*, respectively, are often used in child rearing; both mean, "holding back or being patient" (Toupin, 1980, p. 83). Lung and Sue (1997) pointed out that Chinese parents may perceive extroverted or autonomous behavior as abnormal. They noted that an adolescent who states his or her opinion about an issue may be perceived by parents as talking back, which is a sign of disobedience. Evidently for members of Asian groups, the concept of openly expressing feelings and possibly drawing attention to oneself may be culturally inconsistent and confusing (Leong, Wagner, & Kim, 1995; S. Sue & Morishima, 1982).

The underutilization of mental health services may be attributed to the desire to avoid shame (Atkinson, Morten, & Sue, 1998; Lung & Sue, 1997). Indeed, many Asians believe that having a psychological problem is disgraceful. As such, Asian Americans may avoid mental health agencies because use of these services is an implicit acknowledgement of the existence of mental health issues. Such issues reflect poorly not only upon on the individual, but more importantly upon the entire family (Lung & Sue). To avoid such shame, the family may seek support from indigenous healers, such as spiritualists, shamans, or acupuncturists. These traditional healers often have no formal mental health training. Mainstream services are considered only as a last resort if symptoms have become very pronounced.

Interracial marriage can be a source of shame for a traditional Asian family. Chai (1998) noted that when Koreans marry outside of the ethnic group, elders in the community view that marriage as unsuccessful and the parents experience shame. In one case, the oldest son of a first-generation Korean family decided to marry a White woman of German descent. The parents

expressed their feelings that the marriage brought shame upon the whole family. In addition, the family severed ties with the son and his wife. The son expressed in counseling following marriage that he rejected his Korean background and identified solely with American culture. He had become assimilated.

ETHNIC IDENTITY DEVELOPMENT

Traditional theories of identity concentrate on the importance of subjective continuity and sameness in adolescence that provides a model for adult personality development (e.g., Erikson, 1968; Marcia, 1966). Erikson noted that identity is based on internal psychological development as a function of childhood identifications, influence of family figures, and one's progressive struggle to synthesize these identifications. However, this theoretical view may not be relevant for Asian Americans because of an added dimension to their identity development. Asian American youth are faced with the challenge of integrating their identity as an ethnic minority group member with their identity as an American. Dubois (1903/1969) echoed this sentiment: "One ever feels his two-ness . . . two souls, two thoughts, two unreconciled strivings; two warring ideals in one . . . body" (p. 5).

In recognition of the complexity of minority identity development, a number of scholars have developed racial and ethnic identity models (Cross, 1991; Helms, 1990; Phinney, 1992). However, most models have been developed and validated for specific populations such as African Americans, and then later applied to other ethnic groups (e.g., Cross). Few models have been developed with Asian conceptions of self in mind (Yeh & Huang, 1996). Moreover, the proliferation of stage-like models presumes that all ethnic minority group members conveniently progress in the same linear fashion. Such an assumption fails to consider within group and between group differences among ethnic groups.

Sodowsky et al. (1995) proposed a model of Asian ethnic identity that considers the complex interaction between the individual and her or his social context. They contended that Asian ethnic identity development is not a linear process. Instead, it follows a bidirectional path whereby an individual's ethnic identity orientation can change over time and across situations. Further, the nonlinear ethnic identity process "does not arise out of lability or stability. Rather, it arises out of the ethnic individual's adaptive principle of flexibility and openness to possibilities" (Sodowsky et al., p. 145). Sodowsky et al.'s model is useful because it takes into consideration Asian conceptions of self. These characteristics include the fact that Asian Americans tend to be high self-monitors and respond to the expectations and judgments of the social context, such as parental expectations and social pressures (Yeh & Huang, 1996).

Min and Park (1999) contended that Asian ethnic identity is developed, in part, by negotiating between the pressure from parents to adhere to Asian cultural values and the expectations of the school system to incorporate Western cultural norms. For example, at home, parents may seek to preserve their Asian heritage by expecting their children to speak their native tongue and demonstrate obedience and respect. In school, however, children are encouraged to devote their time and energy toward becoming "Americanized." Park (1997) contended that Asian Americans may feel caught between cultures, neither of which they completely understand. Frustration may emerge as they attempt to balance an Asian identity at home with an American identity at school (Liu, Yu, Chang, & Fernandez, 1990).

In some cases, following exploration and reflection about one's commitments to a variety of domains (e.g., ideology, lifestyle), resolution of these conflicts can lead to the development of an integrated identity. One Chinese woman expressed the complexity of integrating two distinct cultures. She stated,

> I live the tension between a Chinese ideal of filial piety and the American way of self-assertion and independent thinking . . . I am both and I value both . . . I extinguish the conflict for today because I am Chinese American, and I do flow effortlessly between two worlds because in my world there is only one. (Ying & Lee, 1999; p. 201)

THE MYTH OF THE MODEL MINORITY

Asian Americans have been characterized as a model minority ethnic group (Peterson, 1966). Despite their heterogeneity, Asian Americans are often viewed as one homogeneous group. Asian Americans are described as diligent, good at math, and generally successful (Lee, 1996). However, D. W. Sue (1994) warned of the potential pitfalls that may accompany such a description. He suggested that such a label can result in one ethnic minority group being pitted against another. Chon (1995) contended, "Using the myth of the superhuman Asian, [majority society] drags [Asians] into the racialization of American politics, creating an Asian buffer between Black and White

America" (p. 240). The Los Angeles riots may be a case in point. Triggered by the acquittal of the four White police officers involved in the beating of an African American motorist, Rodney King, increasing reports of discrimination and hate crimes emerged between Koreans and African Americans (Sasao & Chun, 1994).

Interpreting these group dynamics, S. Sue (1995) suggested that majority society has created the myth of a model minority to ensure racial division and preservation of White privilege. Often, the Asian model minority image is used against other minority groups to silence their claims of social inequality. By acknowledging that one minority group can attain success, it can be argued that race is not a handicap within the United States. In the end, according to Lee (1996), the seemingly positive image of the Asian American only serves to perpetuate the White-dominated social structure.

Proponents of the model minority myth have claimed that Asians tend to achieve higher scores on standardized tests compared to other ethnic groups (Kim & Chun, 1994). They have concluded that Asians are more educated than other ethnic groups. Offering an opposing view, D. W. Sue and Sue (1990) concurred that on the average, Asians appear to attain high test scores. However, upon further analysis, they pointed out that a bimodal distribution appears to separate a portion of Asians with superior educational prowess from a highly undereducated mass. The average score seems to indicate Asian intellectual superiority, but further examination reveals that a large number of Asians are undereducated.

Another reason that Asian Americans have been depicted as a model minority is that they underutilize mental health services. Some have erroneously interpreted this to suggest that Asian Americans are psychologically healthier than other ethnic groups. However, research suggests that Asian Americans have underutilized traditional psychological treatment primarily because of cultural influences (Atkinson, Lowe, & Matthews, 1995; Cheng, Leong, & Geist, 1993; Leong et al., 1995). Indeed, Cheng et al. (1993) pointed out that the stigma that is associated with presenting emotional and interpersonal problems may potentially bring shame upon the family name. Hence, Asian Americans may be more likely to express their psychological conflicts somatically or circuitously under the guise of academic counseling. Compelling research has shown that Asian Americans have been found to have as many if not more problems than do the majority population (Vega & Rumbaut, 1991). Cheng et al. and S. Sue and Morishima (1982) found that Asian Americans scored higher on clinical and diagnostic tests compared to White Americans.

Salient problems are associated with the model minority designation. First, Asian Americans may find that they are not eligible for minority benefits such as affirmative action. For instance, Feinberg (1988) found that to get into the elite schools Asian Americans had to score on average 30 points higher on the SAT than their White counterparts did. Another problem is that this model minority designation lowers research interests and institutional priorities related to Asian Americans' mental and physical health. This designation implies that Asian Americans do not face any of the same problems that other ethnic minority groups experience, such as racism, marginalization, poverty, and alienation. In essence, the label of model minority masks the true social problems that Asian Americans experience (D. W. Sue, 1994).

Toupin and Son (1991) and Lee (1994) suggested that some Asian American students may internalize the pressures and expectations associated with the image of model minority. If internalized, this designation may encourage the individual to maintain a traditional Asian identity, thereby preventing further exploration of other identity domains. Lee (1994) identified a group of high school students who seemed to fit the acculturation status of separation. These adolescents spent much of their free time studying during and after school. They expressed that their parents pressured them to excel academically so that they could become engineers and doctors. These students also expressed that they experienced the feeling that they had to live up to inordinately high expectations from professors and classmates to sustain the image of the model minority student. Lee (1994) suggested that the label serves as a barrier to identity exploration and reinforces stereotypical images of Asian Americans.

IMPLICATIONS FOR COUNSELING

A knowledge and understanding of Asian cultural values and traditions may help counselors to help Asian American clients work through issues related to acculturation. Moreover, counselors should be aware that traditional theories of counseling and therapy may need to be modified to be effective with this population.

Some cultural practices such as child rearing must be viewed in light of the context of Asian culture. For example, a psychodynamic perspective may judge close attachments between mother and child beyond the first 3 years of the child's life as maladaptive and pathological. A counselor, operating from a psychodynamic orientation, may need to consider that close attachments between child and mother are a normal part of life in Asian cultures (Locke, 1998).

Counselors should also recognize the role that shame plays in the lives of Asian Americans. Infused within the social and cultural fabric of Asian culture, the notion of shame is the most powerful motivating force in most social interactions and is ostensibly linked to maintaining group harmony. This is true even for assimilated Asian Americans, many of whom have been socialized with traditional Asian child-rearing strategies, which may have instilled the importance of avoidance of shame.

As Asian Americans grapple with their identification between Asian and American culture, they may feel confused and frustrated. Counselors may be effective in helping clients to negotiate between these worldviews and to offer ways in which they can become integrated. Exploration and identification of these cultural issues may lead to a deeper awareness and understanding of their ethnic group membership and the meaning it holds for them.

Last, counselors should be aware of the effects that the label of model minority has on Asian Americans. The review has shown that the label in many ways perpetuates the myth that Asian Americans are not hampered by discrimination, are highly educated, and are mentally healthier than other ethnic groups. These myths misrepresent Asian Americans and place inordinate pressure on them to fulfill these expectations. Counselors may need to encourage clients to discuss their views on the model minority myth and express how they have been influenced by it.

The purpose of this article was to present an overview of issues and concerns that may be relevant in the counseling process with Asian Americans. Despite the fact that Asian Americans are a heterogeneous group, research suggests that most Asian Americans must negotiate some common issues (Lee & Zane, 1998). These issues include socialization processes that differ from that of majority society, the cultural value of shame and its influence on behavior, the complex process of ethnic identity development, and dealing with the model minority myth. As individuals deal with these issues, they may arrive at one of four possible acculturation outcomes (i.e., separated, marginal, integrated, and assimilated). Counselors who are able to develop a knowledge and understanding of the struggles related to acculturation conflicts may improve the overall delivery of mental health services to clients from Asian populations.

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Counselor Response Choices to Prejudicial Client Statements

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Researchers attempted to determine if training in multicultural counseling and counselor gender affected the way that counselors responded to prejudicial statements made by clients. As part of a stratified random sample selected from the Directory of National Certified Counselors, 192 counselors (72% female, 92.2% White, 4.7% Black, 1.6% Latino, and 1.5% mixed or "other") completed a questionnaire with regard to their preferred responses when clients make prejudicial statements. Neither training in multicultural counseling nor a counselor's gender appeared to significantly influence their responses to a client's prejudicial statements. Suggestions for future research are made.

Counselors have responded to the rapidly changing clientele needs that have evolved as a result of the increasingly diverse population of the United States. Both the Council for Accreditation of Counseling Related Educational Programs (CACREP; 1994) and the American Psychological Association (APA; 1990) have stressed the importance of the development of multicultural awareness. Approximately 90% of counselor education programs have been found to contain courses in multicultural counseling (Das, 1995). Thus, within the profession we noted considerable support for the observation that, "Race, culture, ethnicity, and sexual orientation must be considered in the counseling process" (Sue, 1996, p. 9). More recently, the Association for Counselor Education and Supervision endorsed a set of multicultural counseling competencies that were developed by the Association for Multicultural Counseling and Development (D'Andrea & Arredondo, 1996). Included among its identified skill areas is the development of counselors who "attend to, as well as work to eliminate biases, prejudices, and discriminatory practices" (Sue, Ivey, & Pedersen, 1996, p. 49). A variety of proposed training experiences has been designed to increase various multicultural counseling competencies.

In addressing counselor educators, Arnold (1993) has called for "the inclusion of accurate information about racial and ethnic groups in all (counselor training) courses as well as the creation of experiential activities to confront biases in our students and in ourselves" (p. 146). Addressing counseling researchers, Good and Heppner (1995, pp. 318–319) have recommended that future investigators conduct "mock interviews to assess changes in students' gender-related counseling skills" after taking a course designed to sensitize students to gender issues in counseling and mental health. In a discussion regarding the assessment of counselor trainee competency in multicultural counseling classes, Coleman (1996) acknowledged that a concern of those students who react most favorably to the class is that not enough time is spent on "specific techniques that are effective with specific problems" (p. 217). Furthermore, when an attempt was made to assess trainee perceptions of a multicultural training course, "a primary concern was their ability to integrate this knowledge with their actual counseling behaviors" (Heppner & O'Brien, 1994, p. 16). Thus, the effect of multicultural counseling training on counselor practice behavior has become a focus of concern for counselor educators, practitioners, and researchers alike.

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Recently, an entire issue of the *Journal of Counseling and Development* (Robinson & Ginter, 1999) was devoted to healing the effects of racism. Books have also been published demonstrating how counselors from diverse theoretical orientations can react to client prejudices (e.g., Sandhu & Aspy, 1997). Furthermore, a model of counselor consultation has been developed (i.e., De La Cancela & Sotomayer, 1993) to fight racism and other negative "isms" (i.e., sexism, classism, ageism, anti-Semitism, heterosexism, and discrimination against the "differently" abled). In discussing how multicultural counseling can be made more effective in fighting prejudice, Locke (1990) has suggested that, among other things, teachers and counselors must be willing to discuss such questions as "What do I do when?" The purpose of this investigation was to contribute to a "frank and honest dialogue . . . in our profession concerning racism, sexism and homophobia" (Sue, 1997, p. 7) by investigating what counselors do when confronted by a client's prejudicial remark.

Currently, a variety of responses to a client's expression of prejudice is possible. For example, Lee (1996), has stated that although counselors should try to understand even the "repugnant" attitudes, behaviors, and values of their clients, counselors "should make a decision to use [their] intervention strategies to vigorously challenge the intolerant nature of a client's belief system" (p. 6). Brinson (1996) has suggested that counselors consider actively fighting racism and has offered ways that this can be accomplished including the classification of racism as a future mental disorder within the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Sue, Arredondo, and McDavis (1992) have stressed the importance of developing culturally skilled counselors who can intervene to "eliminate bias, prejudices, and discriminatory practices" (p. 486). Cook (1992) has underscored the importance of (a counseling) supervisor's encouraging his or her supervisees to initiate discussions of racial identity issues with clients and has cautioned that to avoid such discussion might deny clients "opportunities to explore a basic part of their identities and the influence of their racial identities on interpersonal relationships" (1994, p. 138). Others have likened prejudice to a culturally-conditioned "habit that can be broken" in stages (Devine as cited in Azar, 1995).

In contrast to these more active intervention suggestions, some might be inclined to favor the counselor's maintaining a "therapeutic stance" in which the product is the (therapy) process. Furthermore, some might believe that a client's prejudicial attitudes may be either reduced as a result of developing greater empathy, trust, and respect for themselves and others. From this perspective, the content, feelings, and deeper meanings of prejudicial statements may be reflected back by the counselor. In addition, a counselor might differentiate between social control and therapeutic counseling believing that the sole purpose of counseling is client symptom elimination and goal attainment (e.g., Haley, 1976). From this perspective, the counselor's focus should be kept on processes related to either the client's problems or goals. Therefore, prejudicial statements that are unrelated to these foci may be ignored. Others who have distinguished therapy from social control have underscored the importance of the counselor's maintaining a position of neutrality (e.g., Boscolo, Cecchin, Hoffman, & Penn, 1987). Although such normative debates over whether a counselor "should" actively intervene to correct social injustices are of vital importance to the profession, the need to investigate what counselors do when a client expresses a prejudicial belief remains.

Myriad variables have been said to affect a counselor's response to a client (Beutler & Hill, 1992). Because one goal of multicultural counselor training is to help produce counselors who can be more effective in dealing with prejudice, it was included as an attribute variable for this study. More specifically, in this investigation we sought to determine if counselors who had been exposed to a multicultural counselor training experience (i.e., a course or a workshop) responded differently to prejudicial client statements than counselors who had not. In addition, because the issues concerning a counselor's response to a client's prejudicial statement include moral decision-making behavior, gender was included as an attribute variable. Although the relationship between gender and moral decision making (e.g., Gilligan, 1982; Kohlberg & Kramer, 1969) and gender and counselor role and associated behaviors (e.g., Beutler, Crago, & Arizmendi, 1986; Jones, Krupnik, & Kerig, 1987; Kaplan, 1979; Maracek & Johnson, 1980) has been previously examined, no previous research has sought to determine if male and female counselors responded differently to prejudicial client statements.

METHOD

Participants

National Certified Counselors (NCCs) were randomly sampled for this investigation. This population was selected because: (a) the NCC credential is an accepted professional standard, (b) NCCs have had to meet uniform educational and practical training, and (c) NCCs are employed in a wide variety of settings (e.g., Borders & Usher, 1992; Loesch & Vacc, 1993). The sample was drawn from a population of 23,131 NCCs as of November 1995. The sample was stratified according to state of residence.

A total of 194 usable questionnaires was returned. Participant demographic information was obtained from responses to the first section of the questionnaire, which 2 participants did not complete. The 192 participants for whom demographic information was available were compared to the samples of other researchers of NCCs on several of the demographic characteristics that were gathered for this investigation. Of the 192, 139 (72.2%) were female, and 51 (26.8%) were male. In Borders and Usher (1992), 66% of the NCCs they studied were female, whereas 70% of the NCCs in Loesch and Vacc's (1993) investigation were female. Gibson and Pope (1993) reported that 51% of the NCCs they studied were female, 35% male, and 14% did not indicate their gender. In the current study, with respect to race, 177 (92.2%) of the respondents were White, 9 (4.7%) Black, 3 (1.6%) Latino, 2 (1%) indicated mixed, and 1 (.5%) "other." In Borders and Usher's study, 88% of the NCCs in their sample were White, 8% Black, and 3% Hispanic. Regarding academic degree, 138 (72.3%) of the respondents in the current study had a master's degree, 16 (8.4%) an education specialist degree, 37 (19.4%) a doctorate, and 3 did not answer the question. In Borders and Usher, 38% of the NCCs had terminal degrees beyond the master's, whereas in Loesch and Vacc's sample of NCCs, 63%, 9%, and 22% held master's, educational specialist, and doctoral degrees respectively. Gibson and Pope reported that 67% of their respondents had a master's degree and 23% had a doctoral degree. These comparisons suggest that the sample used in this study was similar to samples of NCCs in other investigations.

Regarding multicultural counseling training, 142 respondents (74.7%) indicated that they had taken a course or a workshop in multicultural counseling, whereas 48 (25.3%) had not. A total of 4 respondents did not answer this question.

With regard to religion, 149 (77.6%) of the respondents indicated that they were Christian, 11 (5.7%) Jewish, 8 (4.2%) mixed, 11 (5.7%) other, and 13 (6.8%) as none. In addition, respondent sexual orientation was 185 heterosexual (96.4%), 6 homosexual (3.1%), and 1 bisexual (.5%).

Data were also gathered regarding the respondents' primary counseling orientation and primary counseling setting. For both of these variables, several respondents gave more than one answer for one or both of these questions. To overcome these problems, response categories were combined within both of these demographic variables to form larger, logical categories. The frequencies for respondent primary counseling orientation and primary counseling practice are available upon request.

Instrument

We developed a two-part survey questionnaire. The first part asked respondents to provide demographic information (i.e., race, religion, gender, sexual orientation, multicultural counseling training, primary counseling orientation, years of practice as a counselor, primary counseling setting, and education level). This was included, essentially, to determine the degree to which the sample matched previously gathered demographic information regarding NCCs. Multicultural counseling training and gender were, as was previously stated, used as attribute variables. The second part, consisting of seven items, we constructed after a multicultural group of eight counselors practicing in a variety of settings was asked how they would respond to a bias statement made by a client in counseling. Response choices were then categorized loosely based on Doyle's (1992) model of counselor role communication skills. An initial model of the survey was field tested by an anonymous random sample of graduates of our Masters of Counseling Program who were members of its Counselors' Alumni Network. After examining their responses and additional feedback to the initial survey, several changes were made to the instrument (See Appendix).

Participants in the final research project were instructed to read seven different counseling vignettes in which a client made a prejudicial statement. On six vignettes, each counselor and client were matched for the variable involving the prejudicial statement. Therefore, the client presented was described as being a member of the same racial, ethnic, religious, and sexual orientation group as the counselor. One vignette,

involving a gender-related prejudicial remark, was left ambiguous because we were interested in exploring counselor responses under nonspecified conditions. For greater detail regarding the vignettes, the reader is referred to the Appendix.

Procedure

A cover letter, survey questionnaire, and stamped, preaddressed return envelope were mailed to 463 NCCs (approximately 2% of the total). The cover letter described the purpose of the investigation, requested respondent participation, and assured confidentiality. Four mailings (November 1996, January, March, and April 1997) were required to reach the targeted number of NCCs because of surveys returned due to lack of forwarding address. The total number of surveys returned was 198 (42.7%). However, two surveys were not used because respondents returned photostatic copies of the questionnaire, and two additional surveys were not included because they were not completed. Thus, the total number of returned, usable surveys was 194 (41.9%). Of these, some respondents did not answer each item and some gave more than one answer to questions asking for only one response.

Data Analysis

The data were analyzed using several methods. First, we examined frequency counts of responses for the seven counseling vignettes. During initial coding of the questionnaire responses, we discovered that several respondents indicated more than one response to some or all of the vignettes. Participants giving more than one response were not included in further analysis for questions in which they gave multiple responses. Thus, the number of usable responses for each of the seven vignettes differs slightly.

Primary analysis consisted of chi-squared techniques. For each vignette, a goodness-of-fit test was applied to test if the distribution of responses was equal across the response categories. Independence tests were then attempted for cross-classification tables of both gender and multicultural training on each vignette (two demographic variables vs. seven vignettes; 14 tests in total).

RESULTS

Counselor Response Choices

The frequency of responses to each of the seven questions is detailed in Table 1. The number of respondents who gave more than one response is indicated in the table, but these respondents were not included in any analysis and the usable *ns* listed in Table 1 do not include those counts. Furthermore, some respondents did not answer all seven questions. Overall, the usable *n* for each question varies from 178 to 185.

For each of the seven questions, we used a chi-squared goodness-of-fit test to evaluate the null hypothesis that the distribution of responses (reflect, probe, confront, self-disclose, ignore, and other) was not significantly different for any of the response categories. The values of the Chi-Squared statistic ($df = 5$), as well as the associated p-value, appear in Table 1. Employing a Bonferroni correction because of the seven multiple tests, the conventional alpha value of .05 becomes .05/7 = .007. Using this criterion, the null hypothesis cannot be accepted for all of the items except Item 4 (religious prejudice) and Item 7 (nonspecified prejudice).

Counselor Response Choices by Multicultural Training and Counselor Gender

Cross-classification tables were constructed for multicultural counseling training and counselor gender by each of the seven vignettes in an effort to conduct chi-squared independence tests. However, the chi-squared independence test is only valid if two conditions are met: All cells in the two-way table must have an expected value greater than 1, and no more than 20% of the cells can have expected values less than 5 (Agresti, 1990). Thus, valid chi-squared tests could be conducted on 8 of the 14 possible cross-classifications (for both the multicultural counseling training and gender variables, Items 2, 4, 5, and 7 met these criteria). Because of the number of tests attempted, a Bonferroni correction was employed on each of the seven items within an attribute independent variable (i.e., the alpha level became .05/7 = .0071). Using this criteria, none of the eight tests yielded significance. Thus, we could not conclude that the counselor response depended upon either of the attribute variables on any of the four items tested.

DISCUSSION

This survey represents a preliminary descriptive investigation of what counselors say they do when their clients make a prejudicial remark. Examination of the cross-classifications of multicultural counseling experience and gender by means of a series of chi-squared

TABLE 1

Frequency of Counselor Responses to Hypothetical Client Prejudicial Remarks

Question	1[a] (%)	2[b] (%)	3[c] (%)	4[d] (%)	5[e] (%)	6[f] (%)	7[g] (%)	Overall (%)
Reflect	99 (51.3)	19 (9.8)	67 (34.7)	32 (16.7)	30 (15.6)	19 (9.9)	26 (13.5)	292 (21.68)
Probe	4 (2.1)	64 (33.2)	48 (24.9)	26 (13.5)	69 (35.9)	69 (35.9)	20 (10.4)	300 (22.27)
Confront	8 (4.1)	28 (14.5)	18 (9.3)	48 (25.0)	30 (15.6)	40 (20.8)	36 (18.8)	208 (15.44)
Self-Disclose	7 (3.6)	20 (10.4)	6 (3.1)	24 (12.5)	15 (7.8)	19 (9.9)	35 (18.2)	126 (9.35)
Ignore	49 (25.4)	31 (16.1)	27 (14.0)	26 (13.5)	20 (10.4)	15 (7.8)	42 (21.9)	210 (15.59)
Other	18 (9.3)	18 (9.3)	12 (6.2)	25 (13.0)	17 (8.9)	18 (9.4)	24 (12.5)	132 (9.80)
Several Responses	8 (4.1)	13 (6.7)	15 (7.8)	11 (5.7)	11 (5.7)	12 (6.3)	9 (4.7)	79 (5.86)
Usable *n*	185	180	178	181	181	180	183	1268
X^2	225.46	50.87	92.53	13.95	66.79	74.40	11.66	132.29
p	.0000	.0000	.0000	.0159	.0000	.0000	.0398	.0000

[a]This question depicted an initial counseling session in which an adult client makes a racially prejudicial remark.
[b]This question depicted a session with an adult client who the counselor has seen for several months and who makes an ethnically prejudicial remark.
[c]This question depicted an initial session with an adolescent who makes a sexist remark.
[d]This question depicted a session with a long-term client who makes a religiously prejudicial remark.
[e]This question depicted a session with a long-term client who makes a prejudicial remark about people with a different sexual orientation.
[f]This question depicted a session with an adolescent long-term who makes a racially prejudicial remark.
[g]This question depicted a termination session in which a client makes a nonspecified prejudicial remark.

tests of independence were conducted. Though somewhat constrained (8 of 14 possible tests could be performed), they showed no significant differences in the response choices within vignettes according to whether or not the respondents had participated in multicultural counseling training or according to a respondent's gender.

The goodness-of-fit tests conducted on each of the seven vignettes suggested that, except for Items 4 and 7, the distribution of responses to the questions was not uniform across all six response categories. In other words, respondents indicated that they would use some types of responses more than others to the various prejudicial remarks on five out of seven of the questions. This might suggest that even though there appears to be no universally employed method of intervention used by counselors when responding to a client's expression of prejudice, not all counselor responses are equally likely. The rejection of the null hypothesis for five of the seven vignettes suggests clusters of agreement among segments of respondents. Of the items in which counselor responses appeared to be more uniformly distributed across the response choice categories, Item 4 concerns a long-term client making a religiously prejudicial remark, and Item 7 is a termination session with a client making a nonspecified prejudicial remark. A closer inspection of possible factors involved in these findings will be discussed next.

In investigating the distribution of counselor response choices for each item, several observations stand out. First, respondents tended to choose reflection of feelings more often during an initial interview than at other times, regardless of the target of the prejudicial remark. Furthermore, the only time a majority of respondents (51.3%) chose the same response was for the initial interview in which an adult client made a racially prejudicial remark. For this item, the second most frequently selected respondent choice was to

ignore the remark (25.4%). Additionally, respondents selected confront (4.1%) and probe (2.1%) least on this item than for any other. Perhaps counselors are more interested in establishing rapport during the initial stage of counseling and are, as a result, less likely to actively challenge the client through any other type of response. We were interested to note that the only other item in which even a plurality of respondents selected reflection of feelings (34.7%) was the third item—the other initial interview vignette. However, for this item respondents selected probe second most frequently (24.9%). The difference in the responses between these two questions may, in part, be explained by differences in the conditions presented. In the former, the client is a depressed adult, and the target of the prejudice is race, whereas in the latter the client is a fighting adolescent whose target of prejudice is the opposite gender. Perhaps different types of clients (e.g., adult vs. adolescent), client problems (e.g., depression vs. fighting), and prejudicial targets (e.g., race vs. gender) affect what a counselor says in response to a client's prejudicial statement during an initial interview.

The one target of a prejudicial statement that recurred in the vignettes presented was someone of a different race. However, the conditions of each item were different. On the first item, covering an initial session, the client was a depressed adult who was worried about not getting a promotion. On the sixth item, the client was a long-term client who was an adolescent. For the former, a majority of respondents selected the response of reflection of feelings more (51.3%), whereas on the latter a plurality chose probe (35.9%). Furthermore, although the second most frequent respondent choice (25.4%) during the initial session was to ignore the remark, the second most frequent choice with a long-term adolescent client was the more active one of confronting the client (20.8%). Again, one can hypothesize that respondents might have varied their responses according to conditions presented, such as age of client, client problem. prejudicial target, and counseling stage. Future investigation is called for to gain greater clarity into the factors that affect a counselor's responses to client's prejudices.

For the item regarding counselor responses to a religious prejudicial remark made by a long-term client, a plurality (25%) chose to confront the client. As was previously indicated, Item 4 (along with Item 7) was found to have had counselor responses more evenly distributed among all of the possible choices than the others. The moral emphases existent in religion may increase the likelihood that confrontation of prejudice directed against those with a different religious orientation will occur in counseling with a long-term client from the same religion as the counselor. The increase in the choice of confrontation might help explain why for this item the null hypothesis (a uniform distribution among response choices) was not rejected. As previously stated, some variation of respondent choice seemed to occur according to target of the prejudicial utterances of long-term clients.

The second item in which respondent response choice distribution supported the null hypothesis was Item 7, the termination session. The most striking aspect of the responses for this item was that a plurality of respondents (21.9%) selected ignoring the remark. Perhaps once the contracted counseling goals have been reached, some counselors are more likely to ignore a client's expression of prejudice than at other times. The increase in the choice of an ignoring response might help explain why for this item the null hypothesis (a uniform distribution among response choices) was not rejected.

Additionally, counselor responses to the prejudicial remarks of long-term clients (several months or longer) were investigated on four items. In each of these, the target of the prejudice varied. Specifically, Item 3 dealt with an ethnic slur, Item 4 involved religious prejudice, Item 5 pertained to sexual orientation prejudice, and Item 6 involved racial prejudice. Although a plurality of respondents chose probing responses with long-term clients who uttered prejudicial remarks regarding ethnic identity (33.2%), sexual orientation (35.9%), and race (35.9%), they chose the probing response less frequently (13.5%) with a long-term client who made a religious prejudicial remark. As was previously stated, on the item with the religious prejudicial remark, the null hypothesis was not rejected.

Some respondents who chose "other" as a response supplemented their answers with additional commentary. One said that in an initial interview he/she would "probably make a note to myself to bring this up later once I've developed more rapport." Once established, "I'd discuss the comment as evidence of prejudice and educate the client about the negative consequences this can have on the client's life." Another said that with a long-term client, "I would further explore how the attitude may be a significant factor in his or her interpersonal problems." A different respondent suggested that with a long-term client he/she would say, "I've always

thought the term (the remark) is harsh. Tell me what it means to you." At termination a respondent offered that he/she "might even harshly critique [himself or herself] for failing to sense this before." Also at termination, another said he/she would say, "During our sessions I've never heard you say (the remark). That usually has a lot of baggage. Is there something we need to discuss further?"

Limitations of the Study

The results of this preliminary investigation should be interpreted with caution because of a variety of limitations. For example, although the overall response rate of 42.7% fell within the lower end of the acceptable range (i.e., Miller & Larrabee, 1995; Weathers, Furlong, & Solorzano, 1993), one should not generalize these findings to all NCCs, let alone all professional counselors because a relatively small percentage of NCCs (2%) was surveyed. Thus, the lack of significant findings between multicultural counseling training, counselor gender and counselor response choices may be a function of sample size. In addition, the instrument used was parsimonious, and though field-tested and adjusted as a result, presented only seven hypothetical situations. Within each situation, conditions were varied. Thus, client characteristics pertaining to their reason for seeking counseling (i.e., worry, a neighbor problem, fighting, nonspecified, etc.), the stage of counseling, and the target of the client's prejudice may have affected the findings. Therefore, the instrument used in this study would need to be adjusted to isolate these possible variables. Finally, the study was an analogic self-report, not an actual counseling encounter. The strengths and limitations of analogue studies have been discussed in the literature (e.g. Goldman, 1976; Stone, 1984). Suffice to say, analogue research could be appropriate for research concerning such variables as, "therapists' initial reactions to various types of clients" (Hill & Corbett, 1993, p. 15).

Implications

This investigation was stimulated by a practicum student's questions after conducting a counseling session with a client who made a racially prejudicial statement. The counselor educator discussed a variety of possible counselor responses, but resolved to ask the same questions to several practitioners. Their answers led to the construction of the questionnaire. Although this study represents a preliminary investigation into how counselors respond when clients make prejudicial remarks, the clearest conclusion reached is that there is not a consensus among counselors with regard to how to best respond to a client's prejudicial statement. As for multicultural counseling training, the failure to find significance may suggest that the typical multicultural course or workshop has little impact on how a counselor responds to a client's prejudicial remarks. However, this research did not differentiate between multicultural workshops, multicultural courses, and specific training experiences in prejudice prevention. Future research differentiating these variables also seems warranted. Furthermore, as multicultural counselor training continues to evolve, perhaps skill acquisition will occupy a larger component of the curricula than what currently exists. We hope that an outcome of this investigation is an increase in the dialogue pertaining to specific ways that counselors can effectively intervene to challenge client prejudice.

The gender variable also did not produce significant differences on the items in which tests were performed. Thus, we could not conclude that male and female counselors react differently to client statements of prejudice. However, we made no attempt to assess the degree of counselor reference group identity (Hyman, 1942). Identity theorists (i.e., Wade, 1998) have hypothesized a relationship between one's reference group identity and behavior in relevant situations. Research has already been conducted into such variables as gender (i.e., Wade & Gelso, 1998) and racial identity (i.e., Helms, 1990). On this project, both male and female respondents may have identified with their role as professional counselors more than with their gender groups while conducting counseling sessions. Though not examined in this study, professional identification may supersede other attribute variables (e.g., race, religion, sexual orientation) when counselors are counseling. Conversely, perhaps the degree to which a counselor identifies with either the client's group or the target group (of the client's prejudice) may significantly impact a counselor's response choice. This appears to be a potentially fruitful area for future research.

Finally, the findings of this investigation suggested some additional avenues for future investigation. Needless to say, the normative debates pertaining to how counselors should intervene in response to client prejudices will continue. We hope that this investigation will help increase the dialogue about what a counselor does when a client makes a prejudicial statement.

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APPENDIX

COUNSELOR RESPONSE CHOICE QUESTIONNAIRE

The following survey has been designed to determine the ways that counselors respond to client bias statements. Please check the one response that would best approximate the way that you would respond to the following:

1) It is your first session with an adult client from the same racial group as yours who has been referred to you because of depression. Your client fears s/he might be passed over for a job promotion by a coworker who is a member of a different racial group. Suddenly, s/he use a prejudicial term to describe the coworker. Which of the following responses is closest to the one that you would use (check one):

a)____ I would reflect their feelings.

b)____ I would probe where they learned to use such language.

c)____ I would confront their use of prejudicial language.

d)____ I would self-disclose my position about their use of language.

e)____ I would ignore the language and work on their depression.

f) ____ Other (GIVE AN EXAMPLE) _____

2) You have been counseling an adult client from the same ethnic group as your own for depression for several months. During a session in which s/he discusses his or her progress, s/he makes an aside in which s/he refers to a different ethnic group using a prejudicial term. Which one of the following responses is closest to the one that you would use (check one):

a)____ I would tend to reflect their feelings.

b)____ I would probe how they came to develop such a perception.

c)____ I would confront their prejudicial remark.

d)____ I would self-disclose my position about their use of prejudicial language.

e)____ I would ignore the term and work on their problem.

f) ____ Other (GIVE AN EXAMPLE) _____

3) During an initial session with an adolescent who has been referred to you for frequent fighting in school, s/he makes a sexist comment (i.e., all boys/girls are _____). Which one of the following responses is closest to the one that you would use (check one):

a)____ I would reflect their feelings.

b)____ I would probe how their perception developed.

c)____ I would confront their use of sexist language.

d)____ I would self-disclose my position about their use of sexist language.

e)____ I would ignore the term and focus on their problem.

f) ____ Other (GIVE AN EXAMPLE) _____

4) A long-term (several months plus) client who is from the same religious group as your own is working through a problem they are having with a neighbor who belongs to a different religious group. Suddenly, your client refers to the neighbor using a prejudicial term for their religious group (i.e., "he/she is a _____"). Which one of the following responses is closest to the one that you would select (check one):

a)____ I would reflect their feelings.

b)____ I would probe where they learned to use such language.

c)____ I would confront their use of prejudicial language.

d)____ I would self-disclose my position about their use of language.

e)____ I would ignore the term and concentrate on resolving their problem with the neighbor.

f) ____ Other (GIVE AN EXAMPLE) _____

APPENDIX *(continued)*

5) One of your long-term clients makes a prejudicial remark about people with a different sexual orientation than the one that you and s/he have. Which one of the following responses is closest to the one that you would use (check one):

a)____ I would reflect their feelings.

b)____ I would probe into where they developed their attitude about this group.

c)____ I would confront their use of prejudicial language.

d)____ I would self-disclose my position about their use of prejudicial language.

e)____ I would ignore the term and concentrate on their treatment goals.

f) ____ Other (GIVE AN EXAMPLE) _____

6) A long-term adolescent client who is of the same racial group as yours uses a prejudicial term to describe the members of a different racial group. Which one of the following responses is closest to the one that you would use (check one):

a)____ I would reflect their feelings.

b)____ I would probe into where they developed their attitudes about this group.

c)____ I would confront their use of prejudicial language.

d)____ I would self-disclose my position about their use of prejudicial language.

e)____ I would ignore the term and concentrate on their treatment goals.

f) ____ Other (GIVE AN EXAMPLE) _____

7) A long-term client from the same racial/ethnic/gender/religious group as your own makes a prejudicial remark about members of a different group during a termination session. Which one of the following responses is closest to the one that you would use (check one):

a)____ I would reflect their feelings.

b)____ I would probe into how they developed their attitude.

c)____ I would confront their use of prejudicial language.

d)____ I would self-disclose my position about their use of such language.

e)____ I would ignore it and concentrate on termination.

f) ____ Other (GIVE AN EXAMPLE) _____

COUNSELOR RESPONSE CHOICE QUESTIONNAIRE

Please check the one answer that describes you best.

1. Race: White ___ Black ___ Asian ___ Latino ___ Other ___ Mixed ___

2. Religion: Christian ___ Jewish ___ Muslim ___
   Mixed ___ None ___ Other ___

3. Gender: Male ___ Female ___

4. Sexual Orientation: Heterosexual ___ Homosexual ___ Bisexual ___

5. Have you ever taken a course or workshop in multicultural counseling?
   Yes ___ No ___

APPENDIX *(continued)*

6. Primary counseling orientation: (Check one that fits best.)

Cognitive-Behavioral ___	Eclectic ___	Existential ___
Family systems ___	Humanistic ___	Person centered ___
Psychodynamic ___	Strategic ___	Other ___

7. Years of practice as a counselor:

None ___	Less than 1 year ___	1-5 ___	6-10 ___
11-15 ___	16-20 ___	21+ ___	

8. Primary counseling practice setting:

Elementary school ___	Junior high or middle school ___
Senior high school ___	College/university ___
Rehabilitation program___	Community mental health clinic or agency ___
Hospital ___	
Career development program/center ___	Private practice ___
	Government ___
Correctional facility ___	Business/industry ___
Vocational/technical school ___	Military installation ___
Counselor educator ___	Other ___

9. Education:

Doctorate ___	Education Specialist ___
Master's ___	Other ___

TURN OVER AND CONTINUE ON THE OTHER SIDE

Biopsychosocial Aspects of Attention-Deficit/Hyperactivity Disorder: Toward a Self-Regulated Behavior Paradigm

Dale Starcher, Ph.D., Garfied Park Academy

In this article, an overview of attention-deficit/hyperactivity disorder (ADHD) is presented from a biopsychosocial perspective, an attempt to circumvent disparate psychological and medical viewpoints and offer a broader, more integrated view of ADHD. Through a review of the current literature on ADHD treatment within the clinical field, as well as intervention strategies for ADHD within the educational field, the author proposes the self-regulated behavior paradigm. This person-centered paradigm uses both pathological and growth-oriented constructs of human nature. As such, it offers the advantage of being able to integrate pathologically oriented approaches with growth-oriented approaches within a single comprehensive intervention plan. The impact of this approach in helping people with ADHD is discussed.

ADHD is one of most researched disorders in medicine (Spencer, Biederman, & Wilens, 2000). The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association, 1994) lists ADHD as a developmental disorder that is usually first diagnosed in childhood. The diagnostic criteria focuses on developmentally extreme symptoms in the domains of inattention and disorganization or hyperactivity and impulsivity that are of early onset (before the age of 7 years), long-standing (at least 6 months' duration), pervasive (displayed in multiple situations), and impairing (*DSM-IV*).

Epidemiological studies suggest that 3% to 6% of the school-aged population suffer from ADHD (Goldman, Genel, Bezman, & Slanetz, 1998). Some researchers claim that ADHD is overdiagnosed, but evidence exists that diagnostic criteria for ADHD are based on extensive empirical research (Goldman et al.). Investigations have led to a diagnosis possessing high interrater reliability, good face validity, and high predictability of course and intervention responsiveness (Barkley, 1998).

ASSESSMENT OF ADHD

Assessment in determining ADHD usually starts with three components: a medical examination; followed by a clinical interview, which includes a family and developmental history; and a behavioral rating scale, consisting of three scales: parent, teacher, and self (Barkley, 1997). Other assessments can help in making a diagnosis: (a) observing the person in given situations; (b) assessment of perceptual skills; (c) continu-

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ous performance tests, which measure inattention, impulsivity, reaction time, and variability (Corkum & Siegel, 1993); and (d) neuropsychological assessment of executive functions (Kempton et al., 1999). A comprehensive assessment battery is important, not only for ruling out other possible diagnoses, but also for further delineating the ADHD syndrome, such as the existence of comorbid symptoms.

In a school setting, such a comprehensive assessment battery is usually provided by the child study team through what is referred to as a "functional behavioral assessment" (FBA). An effective FBA would not only provide historical and evaluative data of the child's symptoms, but would also provide clear guidelines on intervention strategies and outcome measures.

MEDICAL INTERVENTIONS: PHARMACOTHERAPY

The use of drugs leads all other interventions in the treatment of ADHD. Comprehensive reviews of research studies clearly demonstrate the effectiveness of medication in treating certain symptoms of ADHD (Spencer, Biederman, & Wilens, 2000). The most widely used medications are the central nervous system stimulants. Stimulants, such as amphetamines, caffeine, and cocaine, cause an inhibitory affect on the brainstem circuitry via the descending neural pathways from the self-regulation region of the brain. This enables a person to ignore new stimuli and hold the attention within a working memory system where goal setting, self-reflection, problem solving, and other cognitive processes can take place. The four most commonly used stimulants are: methylphenidate (Ritalin), dextroamphetamine (Dexedrine), pemoline (Cylert), and dextroamphetamine aspartate (Adderall). Methylphenidate is the most prescribed of all stimulants. Consequently, this drug has the largest body of research supporting its effectiveness. For example, single positron emission computerized tomography analysis has demonstrated that methylphenidate increases dopamine availability in the frontostriatal region and improves symptoms in people with ADHD (Krause, Dresel, Krause, Kung, & Tatsch, 2000). Functional MRI studies have shown that methylphenidate increases dopamine functioning in the basal ganglia in people diagnosed with ADHD, and that this is correlated with improvement in motor functioning (Teicher et al., 2000). Other studies on this drug have shown: (a) increased reaction time, accuracy, and speed (Krusch et al., 1996); (b) improvement in sustained attention, working memory, and motor steadiness (Zeiner, Bryhn, Bjercke, Truyen, & Strand, 1999); (c) visuospatial orienting (Sheppard, Bradshaw, Mattingley, & Lee, 1999), and improved response inhibition (Vaidya et al., 1998).

Various antidepressant drugs have been found to be effective in selective cases. Spencer et al. (2000) found 33 studies demonstrating the effectiveness of antidepressants for ADHD. Cholinergic drugs have also been used in treating ADHD. This is based on the "nicotine hypothesis" of ADHD, because nicotine has been shown to enhance dopaminergic release (Dalack, Healy, & Meador-Wookruff, 1998). Various researchers have found cholinergic drugs to be effective in helping certain symptoms of ADHD (e.g., working memory and sustained concentration improved; Meck & Church, 1987).

In conclusion, few researchers would question that drug therapy has proven helpful in treating many of the ADHD symptoms. However, nondrug approaches are also needed for the following reasons:

1. Drugs for ADHD are powerful artificial substances. The toxic side effects related to these drugs are stated in the *Physicians' Desk* Reference (2001).
2. These drugs travel via the bloodstream and into the central nervous system; thus, they cannot go to only one part of the body. Therefore, other areas of the body will be affected, and we simply do not sufficiently understand all of the interactive affects of the different neurotransmitter, neuronal, and biochemical subsystems to know all of the possible effects a drug may be having (Austin, 1999).
3. Most ADHD sufferers have comorbid symptoms (Barkley, 1997) and more than one drug is often prescribed to address each symptom. This further enhances the above-mentioned concerns.
4. Medications for ADHD are compensatory, not curative (Barkley, 1997). Therefore, the only logical research response is to continue to search for more effective approaches (with fewer downsides).

BIOPSYCHOSOCIAL FACTORS

A review of the literature indicates that ADHD represents a syndrome in which many mind-body subsystems are involved. Figure 1 shows the different interpsychic and intrapsychic systems that have supportive research indicating their role in ADHD symptoms.

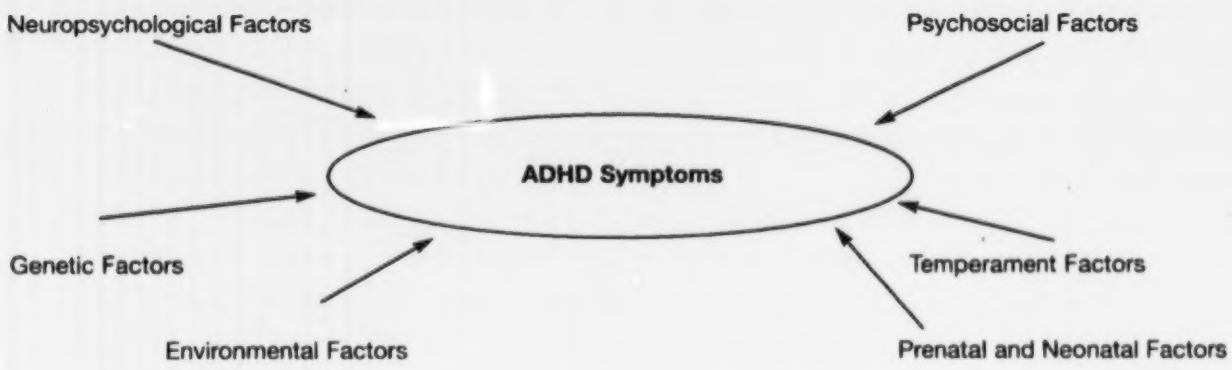

FIGURE 1
Biophysical Aspects of ADHD symptoms

Neuropsychological Factors

Most counselors and psychologists do not have a strong background in neuropsychology or psychopharmacology. However, a basic understanding of these fields as they apply to ADHD can be useful. This is helpful when interacting with the medical profession and when trying to relate the medical perspective to psychology. With this knowledge in hand, we are also in a better position to understand and appreciate how and why nonpharmacological interventions for ADHD impact on the brain and neurochemical system. This allows the counselor to directly compare drug therapy with nondrug therapy strategies.

Inattention is one of the primary symptoms of ADHD. Parasuraman (1998) pointed out in *The Attentive Brain* that varieties of attention exist and many brain-mind systems are intimately involved in attention. Theorists have also viewed the various parameters of attention in different ways, which adds to the difficulty of understanding the role of attention in ADHD. There are, however, commonly used concepts of attention. For the sake of discussion, in this article, attention is demarcated around (a) vigilance or sustained attention, (b) selective or orienting attention, and (c) divided attention.

Attentional processes are sometimes separated neuroanatomically between posterior and anterior regions of the brain. In the posterior region, at the level of the brainstem, attention begins in the form of arousal, alertness, and an orienting reflex. Selective attention is also related to this region. In a general sense, the role of these structures is to orient the mind to novel stimuli through information from the exteroceptive and proprioceptive sensory systems. Most of the neural structures corresponding to arousal and attention are located in the reticular activating system of the brainstem, which has multiple neural connections, both to the peripheral nervous system and to most brain regions, and possesses both active and inhibitory features (Pliszka, Maas, Javors, Rogeness, & Baker, 1994).

In the anterior region of the brain, attentional processes correspond mostly to the frontostriatal system. This neural network is represented neuroanatomically by the prefrontal cortex and the basal ganglia and its related neural sites. The prefrontal region corresponds, psychologically, to the executive functions, including self-regulation, impulse control, planning, simple and complex problem solving, organization, self-reflection, and self-awareness (Barkley, 1997). This region is most often correlated with sustained and divided attention (and, for some theorists, attentional control).

The other primary symptoms of ADHD are impulsivity and hyperactivity. Some of the descriptors include impatience, difficulty in delaying responses, interrupting others, fidgetiness, and excessive physical activity. Impulsivity and hyperactivity often occur together. The ability to control one's impulses is directly related to the executive functions, especially the right frontal region. The ability to control motor activity is also related to the frontal cortex, but through interconnections with the basal ganglia and motor cortex.

Barkley (e.g., 1995, 1997, 1998), one of the leading researchers in the psychology of ADHD, has devel-

oped a "behavioral disinhibition" theory. He believes that the lack of impulse control is the most significant issue in ADHD. In fact, he excluded inattention as a significant factor. Because the executive functions are mostly (although not exclusively) responsible for inhibiting responses to novel stimuli (which is necessary for sustained and divided attention), Barkley (1997) has targeted these functions as holding the key to understanding ADHD.

Besides inattention, impulsivity, and hyperactivity, researchers are beginning to delineate other cognitive deficits in persons with ADHD. Williams, Stott, Goodyer, and Sahankian (2000) also found significant impairment on spatial span and have suggested that this reflects parietal lobe problems. Bradshaw and Sheppard (2000) found left visual field neglect. Berman, Douglas, and Barr (1999) found reduced performance on a complex visual-memory search task. And Aman, Roberts, and Pennington (1998) found deficits in visual-spatial cuing tasks and spatial relations.

A study conducted by Kempton et al. (1999) is an example of the specificity of cognitive factors that are being correlated with ADHD. Using the Cambridge Neuropsychological Test Automated Battery (Luciana & Nelson, 1998), they were able to delineate the following impairments: executive planning, movement time (number of steps required to problem solve), attentional set shifting, spatial working memory, visuospatial memory, spatial recognition, delayed matching, difficulty in applying cognitive rules to new but similar situations. These cognitive impairments correspond, for the most part, to the executive functions and to the frontostriatal system, although other brain regions, such as the parietal region, may also be involved. According to Kempton et al., many of these symptoms indicate that those with ADHD are "not yet able to develop systematic strategies to assist performance" (p. 535).

Because of the complexity, and in some cases disparate views, integrating the research that has been presented thus far could be helpful. Fortunately, this has already been done. Theorists have proposed various models that represent attempts at offering more integrative constructs of brain and neurocognitive processes and ADHD:

1. Posner and Raichle (1994) identified three core divisions. The first is an inattentive type where sustained attention and effort are dysfunctional. This type is related to the right frontal cortex, with connections to the right posterior parietal and the locus ceruleus. The second is an inattentive type where selective attention is dysfunctional. This type is related to the posterior parietal cortex, with connections to the bilateral parietal, the superior colliculus, and the thalamus. The third is an impulsivity and hyperactivity type where divided attention and executive control are dysfunctional. This last type is related to the anterior cingulate, with connections to the anterior cingulate, the left lateral frontal, and the basal ganglia.
2. Malone, Kershner, and Swanson (1994) developed a left hemisphere and dopamine deficit theory.
3. Voeller and Heilman (1988) developed a right hemisphere and norepinephrine deficit theory.
4. Swanson et al.'s (1998) right hemisphere and norepinephrine theory correlated with inattention. Their left hemisphere and dopamine theory is correlated with impulsivity and hyperactivity.
5. Pliszka, McCracken, and Maas's (1996) multistage model involves the peripheral nervous system, the posterior brain region, and the anterior brain region.

Other Biopsychosocial Factors

Twin studies, adoption studies, and evidence of a greater prevalence of psychopathology in the parents and relatives of people with ADHD than among the general population point to genetic influences. Overall, this research supports ADHD as a trait that is highly hereditary (Barkley, 1997).

Prenatal factors have also been related to the later development of ADHD. Most of the studies have found a relationship with alcoholism, drugs, and tobacco use (Shen, Hannigan, & Kapatos, 1999; Tizabi, Popke, Rahman, Nespor, & Grunberg, 1997), although other factors may be included: tissue hypoxia during the prenatal period, which can interfere with the formation of the frontostriatal circuits and possibly lead to behavioral disturbances (Toft, 1999), and exposure to early adverse events (Graham, Heim, Goodman, Miller, & Nemeroff, 1999).

Environmental factors have been correlated with the development of ADHD. Physically induced stressors include such factors as malnutrition, toxins, diseases, and traumas. For example, elevated lead levels have been shown to have a small but consistently significant

relationship with certain symptoms of ADHD (Barkley, 1997). Kidd (2000) stated that food additives, intolerance to foods, sensitivities to environmental chemicals, and exposure to heavy metals can be related to the development of ADHD in some cases. Researchers have found that children with ADHD may have an increased sensitivity to simple sugars, which may contribute to some of their symptoms (Browne & Sutton, 1995). Particular nutritional substances may also have some benefit in treating the symptoms of ADHD (Dykman & Dykman, 1998). A final example is evidence correlating previous head injury with the development of ADHD symptoms (Herskovits, Megalooikonomou, Davatzikos, Chen, & Bryan, 1999).

Psychosocial factors that have been implicated in the development of ADHD symptoms include marital distress, family dysfunctions, and low socioeconomic class (Faraone & Biederman, 1998; Fischer, 1990; Swallow, 1998). Because most of this research centers on the effects of psychosocial stress on biochemical and neurophysiological functions, this will be addressed in a separate section.

Finally, the role of temperament is significant. Most researchers currently view temperament as having a strong genetic basis but capable of being modified through one's lived experiences (Hallahan & Kauffman, 2000). Some evidence also exists for correlation between different temperaments and ADHD. The strongest evidence comes from such research as Thomas and Chess's (1984; see also Kazdin, 1997) investigations indicating correlation between different temperaments and the predisposition to develop emotional or behavioral disorders. A one-to-one relationship between temperament and disorders, however, has yet to be identified. Researchers such as Peled, Carraso, Globman, & Yehuda (1997) have moved closer to such identifications. These authors have described three behavioral styles of people with ADHD symptoms.

Individual differences are also evident when one considers the presence of comorbid factors in those with ADHD. From individual to individual, one or more different comorbid symptoms (e.g., anxiety, learning disorder, oppositional defiant disorder, conduct disorder, depression) can exist.

DIATHESIS-STRESS MODEL

One of the models used in this review as a way of accounting for the different etiological variables of ADHD is the diathesis-stress model. This view represents an integrated theory of psychopathology. The diathesis component refers to a biological vulnerability to develop a particular pathological response. Stressful life events represent the stress component of the model. The biological vulnerability is believed to be an overactive psychophysiological response to stressful life events or situations (Brown & Barlow, 1997). A genetic predisposition alone is insufficient in predicting the manifestation of certain psychopathologies. Research (see below) supports the view that stress plays a crucial role in whether a disposition remains inactive or becomes activated. ADHD is an example of one such psychopathology.

A growing body of research demonstrates a significant relationship of stress with the development of ADHD symptoms. Austin (1999) stated that, in the early stages of stress research (during the 1960s and 1970s), researchers demonstrated that stress activates two major systems in the body: hormonal and neural. Stress activates immune system responses and the hypothalamo-pituitary-adrenal axis, resulting in autonomic nervous system responses and endocrine secretions on peripheral organs. More recently, a third route of stress responses has been studied; this is the avenue through which stress directly affects the brain and neurochemical system (Arnstein, 1999; Skosnik, Chatterton, Swisher, & Park, 2000).

A direct effect on the brain is possible through a functional integration of the hypothalamo-pituitary-adrenal axis and the system of corticotropin releasing factor neurons. As Austin (1999) stated, stress causes a release of corticotropin releasing factor and acetylchomine widely throughout the diencephalon and the upper brainstem. Included in these changes are altered activations and changes in mood associated with noradrenergic and serotonergic systems (Lovallo, 1997). Neuroanatomically, stress appears to have the greatest effect on prefrontal, limbic, hypothalamic, and brainstem functioning. A review of the literature has revealed a variety of changes in the neurotransmitter systems as a result of stress.

Norepinephrine system. Horger and Roth (1996) and Konstandi, Johnson, Lang, Malamas, and Marselos (2000) have found a broad range of negative effects on norepinephrine. Chronic stress depletes the norepinephrine and alters the ability of the prefrontal cortex, amygdala, and hippocampus to evaluate incoming stimuli, as well as formulate and initiate behavioral responses. Funk and Stewart (1996) have also noted

negative changes in the activation of the prefrontal cortex. Additionally, negative changes in attention (Skosnik et al., 2000) and posttraumatic stress disorder (Southwick et al., 1999) have been correlated with changes in norepinephrine levels caused by stress.

Serotonin system. Uncontrollable social stress, especially early in life, can produce chronic reductions in serotonin, with subsequent changes in behavior and emotions (Higley, Suomi, & Linnoila, 1992; Isogawa et al., 2000). These changes can remain long after the early social stressors cease.

The dopamine system and related frontostriatal region. Significant data supports the effects of stress on the frontostriatal system and the corresponding dopamine system. Early research supported the view that stress had a generalized stimulating effect on these systems. Horger and Roth (1996) stated that the mesoprefrontal dopamine system is particularly vulnerable to stress and causes an activation of this system. Other researchers have concurred with this view (Adler et al., 2000; Funk & Stewart, 1996). Because stress tends to stimulate dopamine release, many researchers believed that stress was not directly related to ADHD symptoms. More current research has challenged this view. Researchers have found that stress can have both stimulating and depressing effects, depending on the brain region and particular dopamine gene (Kurata, Tanii, Shibata, & Kurachi, 1993; Wu, Yoshida, Emoto, & Tanaka, 1999). Other researchers have found that stress can have a depressing effect on this system (Arnstein, 1999; Berridge, Mitton, Clark, & Roth, 1999; King, Barkley, & Barrett, 1998). In general, researchers have found that short-term stress tends to stimulate dopamine release, whereas more chronic stress can often result in a depression of the dopamine system. In addition, even brief, but frequent stress can result in a kind of exhaustion of the dopamine system, which can then produce a decrease in the dopaminergic response.

The peripheral neurotransmitter systems. Stress has a broad range of effects throughout the mind-body system. The effects of stress on other systems besides the brain have also been correlated with ADHD. For example, research data supporting the role of the sympathetic nervous system in ADHD, and a correlation of peripheral catecholamine functioning and ADHD is especially evident (Baker et al., 1993; Pliszka et al., 1994; Spivak et al., 1999).

Overall, this research clearly supports the view that impingement of stress on physiology and psychosocial functioning can directly impact brain and neurochemical functions related to the development of ADHD symptoms. Combining this research on stress with earlier discussions highlights the need to expand conceptions surrounding the development of ADHD.

For example, returning to Pliszka et al.'s (1996) multistage model discussed earlier, one finds that stress is involved at all three stages—the peripheral nervous system, the posterior brain region, and the anterior brain region. Including the research on the role of stress during early development, one now arrives at a view in which both genetic and stress factors impact on different areas of the mind-body system and within different time sequences.

Shifting the focus to clinical intervention, researchers need to conceptualize an intervention model of ADHD that incorporates the diathesis-stress view. Because of the strong genetic role in ADHD, whether interventions are effective depends on whether the stress-related central nervous system and peripheral bodily activations have been reduced. Because stress-producing psychosocial factors can be directly correlated with ADHD symptoms, then it is a logical extension to surmise that changing psychosocial factors that cause stress could reduce ADHD symptoms. A growing body of evidence supports such a view.

BEHAVIORAL AND COGNITIVE-BEHAVIORAL METHODS

In a review of the literature, I found that behavioral and cognitive-behavioral methods dominate all other psychological approaches in the treatment of ADHD. However, very few therapeutic programs in school settings address ADHD alone. Instead, most programs are focused on emotional and behavioral disorders as a whole. The majority of the students who are referred to child study teams, though, tend to have either a primary or secondary diagnosis of ADHD (usually comorbid with oppositional defiant disorder and, to a lesser extent, conduct disorder). Therefore, most of the programs reviewed included methods for addressing ADHD.

Over the past 5 years, the National Institute of Mental Health (NIMH) and six academic research sites have undertaken a major treatment study for ADHD (Pelham, 1999). NIMH selected ADHD as the first childhood mental health disorder for which to conduct a large, randomized clinical trial of treatment efficacy. This landmark study, known as the Multimodal Treatment Study for Children with ADHD, now com-

plete, is expected to have a significant impact on future research and clinical practice. Consequently, I selected it as an important indicator of what current research is telling us about ADHD in terms of clinical effectiveness.

Pelham (1999), one of the primary researchers in the study, described the four treatments they offered for ADHD: behavioral treatment (BT), medication management (MM), combined BT and MM, and a community comparison control group. The study generated an extremely complex and multifold data bank of information that will continue to be analyzed over the next few years. To summarize, the study showed that all four treatment groups had dramatic improvements from baseline to 14 months. MM was superior to BT on parent and teacher ratings of inattention and teacher ratings of hyperactivity, but not on any of the other 16 measures. Combined treatment was better than BT on parent and teacher ratings of inattention and parent ratings of hyperactivity-impulsivity, parent-rated oppositional behavior, and reading achievement, but not on any other measure. Both MM and combined treatments were generally superior to community treatments (Pelham).

Pelham (1999) described certain limitations of their study. For example, medication treatment was never phased out, even though behavioral treatment was withdrawn. Had BT been continued in the same way as in the MM group, the effects of BT might have been much more significant as compared to the MM group. Of course the study was based on the generally accepted assumption that medication should never be discontinued because treatment benefits would immediately cease. Physicians have assumed that behavioral treatments should be stopped at a certain point and that the benefits should continue. Pelham admitted that this approach was not an accurate comparison of the benefits of MM versus BT. Yet, despite being phased out, BT was still almost as effective as the ongoing MM. Pelham concluded that behavioral treatment offers a valid, clear alternative to medication, although a combination of treatments seems to be the most effective. In Pelham's opinion, medication should never be used alone unless the concern is only for short-term outcome. This study clearly validates the significant role that behavioral methods can play in treating those with ADHD. Whether used in conjunction with a medication regimen or independently, behavioral interventions offer a viable treatment approach.

A review of the literature has shown that the majority of programs treating ADHD and related symptoms recognize the significant role of generalization skills and self-management training (Hinshaw, 2000). Over the past 20 years, mental health professionals have placed greater emphasis on teaching children self-management skills that will help them function in environments other than where the skills are taught (Shapiro, DuPaul, & Bradley-Klug, 1998). Self-management usually includes self-monitoring, self-evaluation, and self-reinforcement. An important extension of self-management training is helping students develop self-awareness and self-reflection. Research has revealed that those with ADHD have very poor self-awareness and struggle with being able to reflect on their behavior (Barkley, 1997). Any training that can enhance these skills would be extremely beneficial.

Because most current behavioral models contain elements that are clearly cognitive in form (such as self-monitoring, self-evaluation, planning, and problem solving), no clear distinction exists between current behavioral approaches and cognitive-behavioral approaches (Hinshaw 2000).

A central issue elucidated in a review of intervention strategies is that current practices increasingly incorporate a conception of intervention that is centered on self-regulation (Nolan & Carr, 2000). An example of two of the more widely used models that incorporate self-regulation are the Boys Town Model (Dowd & Tierney, 1992) and the Teaching Family Model (Timbers, McWhorter, Ownbey, & Jones, 2000). For instance, a recent study funded by the Georgia Department of Education at the South Metro Psychoeducational Program used the Boys Town Educational Model (Swan, 2000). A published report of the results of a 5-year strategic plan indicated the following results: For elementary students, statistically significant increases were identified in all four scores of teacher-preferred behaviors, peer-preferred behaviors, school adjustment, and total score. For adolescent students, statistically significant increases were identified for all four scores of self-control, peer relations, school adjustment, empathy, and total score. And across all diagnoses, the majority of the students were *able to decrease or eliminate medication usage* over the 5 years.

By including the research on stress (as reviewed earlier in this article), counselors can integrate the use of intervention models with the stress construct. This inclusion enables the counselor to directly correlate

intervention strategies, not only with psychosocial changes, but with neurophysiological changes as well. The connection between psychological intervention and neurophysiological drug intervention enables greater communication between medical and psychological practitioners and provides a larger conceptual framework from which to understand ADHD. The counselor can now clearly understand how psychological interventions directly impact on the same mind-body domain as that of the medical practitioner. However, whereas psychopharmacological agents are compensatory, psychological treatment attempts long-term changes.

THE SELF-REGULATED BEHAVIOR PARADIGM

The medical model of modern allopathic medicine represents a particular philosophical paradigm in health care. This paradigm is one in which the human being is conceptually reduced to biological structures and functions. In addition, the focus is almost entirely on pathology within the biological system. The diathesis-stress model represents a broader view than mere biology; it incorporates psychogenic factors with biological factors. It is, however, philosophically reductionistic and pathologically oriented. Like the medical model (and in the field of psychology, like psychoanalysis) many of the currently held views in mainstream psychotherapy still hold to this pathological conception.

In addition to these pathological views, however, there is a view that incorporates both pathology and growth: the self-regulated behavior paradigm, which represents a major shift in the way human beings are conceptualized. This paradigm has a long historical tradition dating back to the Romantic philosophy and medicine of 19th-century Europe. This philosophy strongly influenced the psychology of Carl Jung and William James. In more recent times, this paradigm has represented the merging of several disciplines, the major influences being humanistic psychology, cognitive neurosciences, systems theory (especially cybernetic theory), behavioral medicine, cognitive-behavioral models, and the meditative disciplines of the East (e.g., yoga psychology; Taylor, 1993).

A closely related paradigm is self-regulated learning, which has been growing rapidly over the last 15 to 20 years in the field of education (Schunk & Zimmerman, 1994). Because most treatment of ADHD takes place with school-age children, the use of the self-regulated learning paradigm begs incorporation with the self-regulated behavior paradigm. In actuality, the two approaches overlap around such issues as classroom management and the way curricula are structured for teaching.

The self-regulated behavior and learning paradigm does not reject the use of outside forces, such as medication or external behavioral controls, to effect change. But according to the paradigm, change also occurs within the person and outside forces are best used when they stimulate the natural self-regulational forces within the mind-body system. For example, even in the behavioral field, those researchers who once argued vehemently for a purely externalized, environmentally controlled model of change now recognize the value of the self-regulation paradigm.

Within this paradigm, medication would be viewed as a single and, hopefully, temporary component that may be used as part of a comprehensive therapy regimen. I view the use of medication in the same way as certain temporary behavioral management strategies. However, if we as health care practitioners have to continue to rely on medication or certain behavioral methods, it would be because of our failure to find better long-term solutions.

In conclusion, the greatest impact in the treatment of ADHD seems likely to come through early intervention. As with treating many learning disorders, such as dyslexia, or other disorders such as autism, health care professionals are increasingly recognizing that they need to start as early as possible in identifying the symptoms and finding viable treatments. This will inevitably involve working more closely with the families. To do this effectively, community-based programs will need to be implemented where long-term treatment can be made available. This does not, of course, mean that other more short-term approaches, or those implemented at a later time will not prove helpful, but they will surely be more difficult. The natural constraints that such factors as age, social influences, and long-term habits can have when trying to elicit change cannot be ignored.

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Student Highlight

Literature Review of Effective Treatment for Dissociative Identity Disorder

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Dissociative identity disorder (DID) is a disorder in which one person has the presence of two or more identities. Although DID is recognized in the Diagnostic and Statistical Manual of Mental Disorders (4th ed. text revision; American Psychiatric Association, 2000), the controversy is ongoing among practitioners as to whether or not it truly exists. This literature review addresses the interpretations, explanations, and treatment perspectives of psychoanalytic, behavioral, and cognitive-behavioral paradigms. A number of generally accepted ideas about the stages of treatment for DID are also discussed. For the most part, these views are from a cognitive-behavioral standpoint and incorporate stages of safety, remembrance and mourning, and resolution or reconnection. Regardless of theoretical background, the majority of DID counselors incorporate the use of the following stances in their treatment: strategic integration, tactical integration, personality-oriented psychotherapy, adaptationalism, and minimization.

Dissociative identity disorder (DID) is a disorder in which one person has the presence of two or more identities. These identities or alter personalities are not separate individuals in one body but they are personalities separate from the dominant or host personality. According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. text revision; American Psychiatric Association, 2000), the individual must have two or more distinct alter personalities that are able to control the behaviors, feelings, and cognitions of the dominant host. The diagnosis also involves amnesia that interferes with the memory of significant life experiences. Finally, the disturbance must not be attributable to a general medical condition or physiological effects of a substance.

Alter personalities may or may not be aware of each other and may have distinctly different histories. DID diagnosis is very complex and is sometimes difficult to distinguish from other disorders. For example, alter personalities often communicate with each other; consequently, the client may report hearing voices—a major symptom of schizophrenia. The client often is unaware of the alter personalities, which lessens the likelihood that he or she would disagree with a diagnosis of schizophrenia. A DID client also is likely to exhibit symptoms of borderline personality disorder; however, a client with DID does not fit the diagnosis of borderline personality disorder because he or she has unusual strength in some areas (Brenner, 1996). Furthermore, clients with borderline personality disorder are more extroverted and tend to engage in black and white thinking by labeling external factors as good or bad, whereas DID clients are more introverted, looking inward into their own private world (Brenner, 1996).

In a case study of a client with symptoms of obsessive compulsive disorder (OCD), Shielagh R. Shusta (1999) found that the client had DID and that the OCD symptoms were a result of lack of communication

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between alter personalities. For example, the client's excessive hand washing was explained by the actions of an alter personality repeatedly taking control without the knowledge that the host had just finished washing. Because symptoms of OCD and DID often overlap, individuals with DID are not usually accurately diagnosed until 6 or 8 years after they begin treatment (Shusta). The majority of DID clients have reported childhood experiences of severe trauma in the form of domestic physical abuse, sexual abuse, or both. The prevailing opinion among psychologists is that the dissociation occurs as a result of an attempt to distance the person from or to disown emotional reactions to this abuse (Shusta). The dissociation may provide an escape from the traumatic event when no other means are possible. Physically, the person cannot avoid the abuse; however, dissociation allows them to disregard that it is happening to them (Phelps, 2000). This in turn allows them to have a "loving" relationship with the abuser, who is often a close relative (Phelps).

Another common characteristic among DID clients is the presence of an alter personality that can be viewed as an internal abuser (Fine, 1999). Catherine G. Fine posited that the child takes on the mindset of the abuser in an attempt to predict when the abuse might occur, and that the internal abuser personality is created as a result of the occurrence of dissociation.

Although DID is recognized in the *DSM-IV-TR* (2000), there is still a great deal of controversy among practitioners as to whether or not it truly exists. Many medical professionals have claimed that the symptoms of DID can be explained as attention-seeking behaviors (Foote, 1999). When confronted by research on the effectiveness of treatment for DID, critics have claimed that the results are tainted by a natural remission of symptoms that would have occurred even in the absence of treatment (Powell & Howell, 1998). According to these critics, the disorder fluctuates between an increase and decrease of symptoms and clients will only seek out treatment when their symptoms are at their worst. Therefore, symptoms likely would go into remission regardless of treatment. Critics also have cited the initial increase in symptoms during early treatment as a result of work with trauma (Powell & Howell). According to Powell and Howell, the difference in severity of symptoms between the beginning of treatment and after 2 years of treatment could be attributed to the absence of intense trauma work that is common in early stages of therapy. Further, if the client's family and the clinician did not reinforce these symptoms, they would cease to exist. The assumption is that the client's unconscious goal is to attract the attention that comes with health crises, and that the counselor creates this disorder by suggesting it as a diagnosis.

Evidence that supports DID as a valid diagnosis includes the fact that clients do not willingly embrace this diagnosis and often fight to reject it. Further, proponents of DID as a valid diagnosis pointed out that symptoms do not cease to exist as a result of ignoring them; rather, this strategy may only encourage the client to stop reporting them (Foote, 1999). In *Dissociative Identity Disorder and Pseudo-Hysteria*, Brad Foote (1999) noted that most of the mental health practitioners who have doubted the existence of DID maintained their doubt when they encountered a client with this disorder, citing that they were not "convinced" that the client's symptoms reflected a DID diagnosis. In an attempt to explain this phenomenon, Foote commented on the effects of countertransferance. By this he meant that a person faced with an elaborate and extraordinary story, assuming that the person begins as a doubter, will naturally have a negative reaction to the report of such events. This observer will view the abrupt changes in cognition, behavior, and affect as superficial, with an increase in variation of identities only serving to strengthen this belief (Foote). In addition, Foote suggested that the error of this doubting perspective lies in the observer's failure to recognize depth in each distinct identity. Critics have posited that the split in identity is shallow and therefore can be described as a horizontal split from a normal level. Horizontal splitting would allow the individual to access different behaviors, affects, and cognitions at a superficial level, floating in and out of these erratic behavior patterns (Foote). Foote suggested that this variance could be explained better as a vertical split where each identity is distinctly different and contains great depth. Furthermore, the counselor's conscious or unconscious negative reactions or skepticism could evoke feelings of powerlessness in clients (Foote). Patients with DID conceivably could have encountered a similar situation if they disclosed that they had been sexually abused and if the person they reported it to did not believe them (Foote). Counselors must be aware of their own parallel processes when dealing with clients. However, special attention should be given to this issue when encountering an abuse victim, as is the case with most DID patients. Counselors also should recognize the controversy surrounding this

disorder and the potential of this controversy to influence the client through external factors. Counselors may want to ask clients with this diagnosis to agree to bring any doubts about the disorder (encountered through literature, other clinicians, or other clients) into the therapy sessions so that they can be adequately processed (Kluft, 1999).

DID TREATMENT FROM DIFFERENT PARADIGMS

DID can be interpreted and explained differently using different paradigms. From the psychoanalytic paradigm, DID is viewed as a character pathology where dissociation is the person's primary defense. The alter personalities are a result of autohypnosis and are aroused as a defense in the here and now due to association with early trauma (Brenner, 1999). During repeated trauma, the individual creates this inner world to escape from the unpredictability of attacks (Brenner, 1999). Furthermore, within the individual is a psychic structure that serves to protect the conscious self by disowning memories and experiences that the person is not yet equipped to address. This structure then personifies these memories and experiences through the alter personalities (Brenner, 1999). The focus of psychoanalytic therapy is to dismantle this inadequate psychic structure. In cases of sexual abuse, those who hold the psychoanalytic perspective have cited defective identification with the same-sex parent as a cause for the dissociation (Phelps, 2000). According to this paradigm, the DID client has a faulty ego structure as a result of the conflict between an abusive parent also being a caregiver (Brenner, 1999). Brenner (1999) stated that the psychoanalytic process does not require accessing any of the client's alter personalities. Rather, the therapist allows the alter personalities to present themselves accordingly when the client experiences anxiety. However, although psychoanalytic views may be beneficial, treatment will not be effective without the use of already established knowledge and techniques (Brenner, 1999).

From the behavioral perspective, DID is discussed as sets of behavioral responses to stimuli. Skinner (as cited in Phelps, 2000) defined *personality* as groups of behavior, which come into play in the presence of the descriptive stimulus. One's personality is a sum of these groups or behavioral repertoires, which suggests that personality is subject to control and modification by environmental factors. Behaviorists believe that all people are made up of these repertoires and that they have developed into one coherent personality through their commonalties. The alternate personalities seen in DID are very diverse and have limited generalization. These are repertoires that have not yet developed into a stable, single personality and therefore may not be viewed as multiple personalities, but as less than one whole personality (Phelps). These repertoires react according to stimulus control, reinforcement, and punishment (Phelps). Because of the unpredictability of the client's early abuse, he or she had difficulty learning what brought about abuse (punishment) or love (reward). Because of this unreliability in their environment, the victim turned to internal stimuli (Phelps). Recurrent dissociative episodes can be explained as learned responses that can be triggered by contextual cues (Meares, 1999). A person with DID has been rewarded throughout life, beginning with early trauma, for remaining less than a whole personality, whereas a person who was not traumatized is rewarded publicly for developing into one coherent personality (Phelps). The focus of behavioral treatment is to extinguish behavioral variability and reinforce generalization. To accomplish this, the counselor points out discrepancies in behavior and encourages the client to ask others to point out these discrepancies throughout everyday life. Again, this strict behavioral perspective should not be applied in absolute terms but should be regarded as a potential resource in addition to more researched and common methods of treatment.

DID STAGES

A few ideas about the stages of treatment for DID are generally accepted. For the most part, these views are from a cognitive-behavioral standpoint and incorporate stages of (a) safety, (b) remembrance and mourning, and (c) resolution or reconnection. During the safety stage, the therapist's goal is to establish a platform from which the client's trauma can be examined. According to Kluft (1999), this stage should create an empathetic atmosphere while strengthening the client as a whole—including all alter personalities—to enhance current functioning. The client should begin to foster communication between alter personalities and learn to control some of his or her alter personalities to avoid self-destructive behavior (Kluft). A process of mapping should begin, wherein the counselor attempts to identify and become more familiar with all of the alter personalities (Kluft). This process also helps the counselor to predict how certain alter personalities might react to issues in therapy and to

choose ally alter personalities that have common goals and can aid in therapy.

In the remembrance and mourning stage, the goal is to bring out past abuse and process it. However, Kluft (1999) stated that the therapist must prepare for this processing. First, she or he should allow for extended sessions so that under no circumstances is a client allowed to leave a session in a dangerous emotional state because of remembered trauma that arose late in the session. Second, the therapist must arrange for a counselor to be available between sessions, in case of an emergency. Third, the therapist must conclude that the client has shown the ability to use skills learned in prior sessions in everyday life. Fourth, the therapist should assess the client as to his or her ability to deal with trauma without regard to DID. For example, can the client effectively deal with depression? Fifth, the therapist should assess the client's current life stressors to avoid any added burdens. Finally, the therapist must determine that the client is motivated to work with his or her trauma (Kluft). It is extremely important not to force this process on the client because forcing it could serve as a reenactment of his or her abuse, which may result in a struggle, submission, or a combination of both (Kluft). The client must understand and appreciate the difficulty and usefulness of working with trauma. Any material that is represented as traumatic must be addressed in order for the client to move toward full integration (Kluft).

In the resolution or reconnection stage, an effort is made for all alter personalities to have successfully worked through the trauma. Increased cooperation, communication, mutual empathy, and identification across all alter personalities are crucial in the process of this stage. Although the DID client must learn to live in the world and make use of alternatives to dissociative coping, clients often resist reconnection or full integration. For these clients, resolution may be a preferable goal. Resolution involves a "smooth collaboration" without integration (Kluft, 1999).

TREATMENT STANCES AND TECHNIQUES

Regardless of theoretical background, the majority of counselors who treat clients with DID incorporate the use of the following stances in their treatment: (a) strategic integration, (b) tactical integration, (c) personality-oriented psychotherapy, (d) adaptationalism, and (e) minimization. The goal of the first three stances is integration. Strategic integration is similar to process-oriented psychotherapy in that the therapist attempts to achieve the same atmosphere for treatment. This stance is focused on the dissociative defenses of the disorder and attempts to alleviate the client's symptoms and difficulties in living. "The condition in essence collapses from within," (Kluft, 1999, p. 293) resulting in integration. Tactical integration is similar to the previous stance; however, it involves the use of discrete goals. The idea is that structure acts as a means of safety for the client (Fine, 1999). Early in the treatment process, the counselor attempts to restructure the client's thinking to prepare him or her for addressing trauma. The goal is to achieve congruence of purpose and motivation between the various parts of the mind (Fine). Although personality-oriented psychotherapy assists the client in becoming integrated, integration is not the goal. Rather, functionality is the focus, and the alter personalities are encouraged to collaborate. Each personality is viewed as an individual and is slowly nurtured back to health (Kluft, 1999). Adaptationalism, stemming from the traditions of supportive psychotherapy, avoids work with trauma and completely focuses on function of the client. This stance may not be appropriate for clients with DID because a client with the potential of a full recovery is denied that opportunity (Kluft). Minimization involves ignoring the existence of the symptoms and is the stance most commonly held by critics of DID diagnosis. According to the minimization view, symptoms of DID are attention-seeking behaviors and will cease to exist if they are not reinforced. However, this approach has not demonstrated widespread clinical utility (Kluft).

The majority of techniques used in treatment, regardless of the counselor's particular stance, are from a psychodynamic or cognitive-behavioral orientation (Kluft, 1999). However, unconventional techniques as well as conventional techniques can be beneficial. One technique is to attempt to address the client in a manner that addresses all of the alter personalities at the same time. The counselor should keep in mind that all of the alter personalities may be listening and should attempt to deal with the person as a system and as a whole (Kluft). Counselors should also encourage the alter personalities to realize that they are part of a whole (Kluft). This is illustrated in Shusta's (1999) case study of a client with OCD. He asked the client to address all of his alter personalities by speaking out loud. In declaring aloud that he had washed his hands, he was able to address the alter personality that felt he was unsanitary and compelled him to excessively

wash. Counselors may also want to consistently encourage any alter personality listening to respond by some means (Kluft). The counselor may want to suggest that the client begin journaling, which could provide an opportunity for reticent alter personalities to emerge, communicate, and vent outside of actual treatment (Kluft). Another technique, which is critical in using tactical integration, is to identify the personalities that are dominant in everyday functioning. By identifying these daily functioning alter personalities, the counselor can avoid prematurely provoking trauma for them, which could seriously affect the functioning of the client before he or she is prepared to address these issues. Fine (1999) suggested attempting to convince alter personalities that their adaptive behaviors are no longer useful. Counselors should also make an attempt to elicit alter personalities in the client and address them directly rather than wait for the client to present them (Kluft). This will aid in the technique of mapping. Mapping, as Fine (as cited in Kluft) suggested, involves an exercise where the host is asked to write his or her name on a piece of paper. The alter personalities are then asked to write their names on the paper in relation to the host. Any alter personality that may be tentative about disclosing his or her identity simply is asked to place a mark on the paper. Fine suggested that this act as an invitation to the counselor to meet each alter personality. This is also beneficial because the dominant personality may not be aware of some of the alter personalities. Therefore, the host cannot be relied upon to accurately map the personalities (Kluft). Another technique that Kluft suggested is to identify cooperative alter personalities that may be able to attend to others. He suggested that higher functioning alter personalities may be able to assist in treatment.

Family and group therapy may help the client and his or her family to cope with DID, but it is not intended for use with the actual dissociation (Kluft, 1999). A danger with family therapy is that any trauma work with the client might involve negative memories of other family members. This would most likely cause family conflict and would only add stress to an already stressful situation (Kluft).

In assessing the type of treatment to employ, therapists should choose a plan that best meets the clients' needs and best respects the clients' wishes (Kluft, 1999). If a client is not ready or not motivated to work with trauma, then integration should not be a treatment goal. The therapist should inform the client that integration will be a choice and that they will make a conscious decision to integrate or not (Fine, 1999). After all, integration in itself can be very stressful for clients who likely have relied on the assistance of dissociation for much of their lives. Integration leaves the client with the problem of daily life (Brenner, 1999). In the perspective of the patient, having just one integrated personality is a disorder (Brenner, 1996). This in itself is reason for continued treatment (Brenner, 1996). Generally, DID patients can be treated effectively with long-term therapy and can go on to lead productive lives (Shusta, 1999).

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